U.S. Department of Justice
Immigration and Naturalization Service

Office of the Commissioner

425 Eye Street N.W.
Washington, D.C. 20536

July 21, 1995

Mr. James Slattery, President
ESMOR New Jersey, Inc.
275 Broadhollow Road
Melville, New York 11747

Dear Mr. Slattery:

Enclosed for your review is the Interim Assessment Report concerning the Elizabeth, New Jersey, contract detention facility operated by your company for the Immigration and Naturalization Service. Based on the findings it contains, we are prepared to let this contract lapse.

Sincerely,

Doris Meissner

Doris Meissner
Commissioner

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The Elizabeth, New Jersey Contract Detention Facility
Operated by ESMOR Inc.

Interim Report
Executive Summary

Background

On May 30, the Headquarters Detention and Deportation Division (HQDDP) was directed by Commissioner Meissner to conduct a program review and investigation of the ESMOR contract detention center located in Elizabeth, New Jersey. Commissioner Meissner directed the review in response to complaints and allegations of abuse and alleged inappropriate conditions of confinement. An Assessment Team was assembled with representation from HQDDP, Headquarters Office of Internal Audit, Eastern Region Detention and Deportation, and the Administrative Center Burlington Administration (Contracting). The review was conducted from June 7-10 and focused on the facility's physical plant, its overall operation, and INS oversight of the contract. Subsequent to the review, a detainee disturbance occurred on June 18, and Commissioner Meissner directed that the investigation be expanded to examine the probable causes of the disturbance, adequacy of response by ESMOR and INS personnel, and emergency plans that were in effect at the time of the disturbance.

Assessment of ESMOR Operations

Based on an overall review, the Assessment Team concludes no real control was exercised over ESMOR guards by their mid-level supervisors. There was some evidence to support the allegations of abuse and harassment of detainees which appears to have been conducted by a small group of ESMOR guards, and usually during the night shift after facility managers had left for the day. The fact that these incidents occurred during the night shift does not, however, exculpate ESMOR management from responsibility for the actions of its employees.

Examples of abuses reported to the Assessment Team were serious. ESMOR guards were implicated in incidents of physical abuse. Theft of detainee property by an ESMOR guard was reported. These complaints were referred to Headquarters Office of Internal Audit. Aliens with final orders of removal refused to board flights to their foreign destinations because their funds, valuables, and property had not been returned by ESMOR employees. Female detainees reported that they had been issued male underwear on which large question marks had been made in the area of the crotch. ESMOR guards frequently awakened detainees in the middle of the night, often several times per night on the pretext of conducting head counts and/or security checks.

The INS Assessment Team found that ESMOR demonstrated a pattern of initiating changes in policy without prior notification to the INS as required. This practice of modifying existing policies and/or implementing new ones without properly notifying INS or receiving INS concurrence materially hindered INS' ability to effectively perform its oversight functions. Moreover, some of the decisions made by ESMOR had a serious negative impact upon relations between the INS and the general public since, in the public perception, INS is inextricably linked to the operations of the Elizabeth facility. The Assessment Team concluded that ESMOR commonly failed to provide, and in some instances withheld from INS, access to important information regarding daily operations and problems in the facility.

ESMOR did not have sufficient personnel and was covering the deficiency with large amounts of overtime. The Assessment Team noted that a high rate of employee turnover and new background investigations requirements protracting the time period for obtaining clearances were factors in creating a shortage of ESMOR guards. ESMOR increasingly relied on overtime to compensate for staffing shortages. The facility has an approximate personnel turnover rate of 60 percent. One factor in the turnover rate was that, the level of salary, predicated upon Department of Labor Wage Determination classification, did not ensure the availability of well qualified applicants in the geographic area where ESMOR is located. Additionally, many of the guards hired by ESMOR did not meet the requirements of the contract or were only marginally qualified. Some ESMOR guards were employed in the facility after merely submitting their investigative paperwork to INS but prior to clearance. Others were employed before receiving the mandatory 40-hour training course. Although the contract required that ESMOR provide a total of 160 hours of training during each employee's first year, many employees had not yet met this requirement. The Assessment Team determined that this task could not be met within the balance of the contract period.

Numerous instances of noncompliance with the terms of the contract were noted by the Assessment Team. Examples of instances of noncompliance include: clean clothing was not provided twice weekly; appropriate footwear and undergarments were not provided to detainees as needed; incident logging was insufficient for INS oversight; and assigned duty posts abandoned or left unmanned by ESMOR employees.

All physical components of food preparation, service, storage, and disposal were found to be adequate. Similarly, based upon findings by PHS, the INS Assessment Team concluded that the individual assessment of detainees who were seen during sick calls was good, although sick call was not conducted on a daily basis as required under the terms of the contract.

The facility was in good order and the physical plant was in good condition prior to the disturbance. Despite the fact the facility was supposed to be designed to meet ACA standards, deficiencies were noted in several areas with regard to American Correctional Association (ACA) standards. These included access to natural light in some areas; lack of privacy in some toilet and shower areas; limited outdoor recreation area; and lack of chairs and writing areas in the segregation cells.

Government Operations and Contract Oversight

Oversight of the ESMOR operation by the Newark District was minimally effective. Communication between INS and ESMOR was insufficient. There was no sense of consistency in the day-to-day operation of the facility or management of the detainees. The staffing structure adopted by the Newark District did not allow for close oversight of this multimillion dollar contract. The Newark District changed management of the facility on at least three separate occasions. During the period of INS staffing changes, ESMOR was able to distance itself from oversight by the INS and conceal information concerning its operations.

After the June 18 disturbance, some ESMOR detainees were transferred to detention space within the jurisdiction of the Philadelphia District Office. INS officers in Philadelphia discovered that, contrary to established INS policy, four juveniles were held in custody at ESMOR, which does have not have appropriate facilities for juveniles.

An inefficient administrative hearing process at the ESMOR facility resulted in lengthy processing times and extended periods of detention in the early months of the contract. As a result, detention costs were high and the removal rate was lower than expected. The INS' contract with ESMOR failed to include necessary provisions to ensure an efficient hearing process. The Executive Office for Immigration Review (EOIR) did not fully staff the ESMOR facility with judges and clerks. The INS was also unable to fully staff the facility with trial attorneys and clerks. In some instances, aliens under exclusion proceedings waited up to four weeks for a hearing after submitting a written request to withdraw their application for admission to the United States. The Asylum Pre-Screening program, designed to identify asylum applicants with credible claims for possible parole by the District Director, was not in place when the facility opened although all detainees who had requested an asylum pre-screening interview ultimately received one. All of these factors led to an estimated average length of stay in detention of 100-115 days.

The Newark District should have taken a more proactive approach toward responding to concerns from the community and local pro bono attorneys. The District should have seen that serious problems were developing and responded in a more meaningful manner to concerned parties. Although the District worked diligently to correct the complaints highlighted by a member of Congress and attorneys, the Assessment Team found little evidence that the results of these efforts were communicated to the interested parties. More could have been done to directly reassure and respond to concerned community interests.

Review of the ESMOR Disturbance

ESMOR did not properly implement its Emergency Plan when needed. ESMOR personnel were either poorly trained in or unaware of the policy and procedures necessary to operate the facility in an effective manner.

The disturbance erupted at approximately 1:15 a.m. on June 18. At the time of the disturbance, there were 14 ESMOR personnel and one INS officer on site. A total of 315 detainees were being housed at the facility at that time. The disturbance was under control by 6:30 a.m. after a tactical entry was performed by local law enforcement officers. There were no significant injuries to anyone involved.

The Assessment Team found that the initial cause for the disturbance was to provide a distraction for detainees who had developed an escape plan. The disturbance began with an assault on an ESMOR guard carried out by five detainees in an organized manner. A second assault was made on another ESMOR guard, and the ESMOR duty supervisor ordered all guards to vacate the facility -- contrary to the Emergency Plan. ESMOR guards had access to riot helmets, batons, and protective shields, but did not avail themselves of this equipment. After the ESMOR guards abandoned the facility, the on-site INS Officer directed them to re-enter the facility in an attempt to establish order. ESMOR personnel refused.

About 15 minutes after the ESMOR guards vacated the facility, the detainees were able to gain access to the interior hallways of the facility by breaking through the dorm windows. The Control Room guard failed to release the security door to the female section, trapping the female guard and uninvolved female detainees inside the facility. During this time, ESMOR guards made no attempt to regain control of the facility or quell the disturbance other than the control post guard calling 911, the local emergency assistance number. At 6:00 a.m., SWAT teams entered the facility and regained control. Order was restored within 15 minutes.

Damage to the facility was limited to the interior of the building and was primarily non-structural. The most significant damage occurred in the control room area. All monitors, a main door-control electronic panel, and closed circuit television equipment were damaged or destroyed. Damage to televisions, tables, and offices within the interior of the facility was heavy. Every interior window in the facility was broken out or damaged. The sinks and toilets were damaged beyond repair. Some cinder block walls were destroyed. The medical, food service, laundry, and INS areas sustained no damage; nor was there damage to sensors, alarms, and comfort control systems.

Detainees cited treatment by ESMOR personnel; frustration over time of detention; lack of communication about their cases; frustration with the hearing process; and deceptive practices by some private attorneys as underlying causes for the disturbance.

The Elizabeth, New Jersey Contract Detention Facility Operated by ESMOR Inc.

Interim Report

I. Introduction

On May 30 the Headquarters Detention and Deportation Division (HQDDP) was directed by Commissioner Meissner to conduct a program review and investigation of the ESMOR contract detention center located in Elizabeth, New Jersey. HQDDP assembled an Assessment Team drawn from the following Immigration and Naturalization Service (INS) Programs: Headquarters Detention and Deportation (HQDDP); Headquarters Office of Internal Audit (HQOIA); Eastern Region Detention and Deportation (RODDP); and Administrative Center Burlington Administration (ACBADM) - Contracting. An Assistant General Counsel, Office of the General Counsel (HQCOU) was requested to assist the Team with legal issues and a review of the Executive Office for Immigration Review (EOIR).

On June 7 through 10, a review was conducted of the Elizabeth NJ. Detention Facility, which is operated by ESMOR Incorporated (hereinafter ESMOR). Areas of particular concern were the facility's physical plant, its overall operation, and INS oversight of the facility. The review was in response to numerous complaints and allegations of abuse, inappropriate conditions of confinement, and of the failure of ESMOR and INS officials to take appropriate corrective action. Complaints were received by ESMOR, the Newark District Office. and Congressman Robert Menendez, in whose district the facility is located. The complaints were further highlighted, prior to and during the review, in several articles in local newspapers. Congressman Menendez, *pro bono* attorney organizations, unidentified ESMOR guards, and relatives of detainees also made complaints to the INS in the detainees behalf.

On June 19, Commissioner Meissner directed the Assessment Team to expand its investigation of the ESMOR facility to include the detainee disturbance which occurred on June 18. The expanded investigation examined the probable causes of the disturbance, adequacy of response by ESMOR and INS personnel, and emergency plans that were in effect at the time of the disturbance.

The damage to the facility caused during the disturbance rendered the facility temporarily unusable for housing detainees. On July 8, ESMOR advised INS that repairs to the facility have been completed. ESMOR has requested an inspection by INS at its earliest convenience. While the physical facility may be available to INS, there are still many open operational and contractual issues to be addressed prior to the facility once again becoming fully operational.

II. Background and History

A. Why Does INS Use Contract Detention Facilities?

In developing its detention strategy, INS has developed the concept of balanced detention resources. INS utilizes Government owned and operated Service Processing Centers, local jail space, and contract detention facilities in order to meet its detention needs. INS has used contract detention facilities since 1984, to complement Government owned facilities. There has never been a previous instance of a disturbance at a contract facility of the magnitude experienced at the ESMOR contract facility.

Contract detention facilities comprise nearly 1,100 bed-spaces. This is roughly 16 percent of the approximately 7,000 total bed-spaces INS has available to detain aliens under deportation proceedings.

Contract facilities offer a number of advantages to the Government. By soliciting private contractors to provide bedspace, INS gains the ability to deploy detention capability into needed locations in a relatively short time. Normally a contract facility can be advertised, awarded, and in operation in 18-24 months, whereas a Government facility requires 4-5 years to appropriate, construct, and staff.

One of the biggest advantages of contracts is that they can range from one year to several years. All contracts have provisions for termination. and longer contracts can include provisions for periodic renewal and renegotiation of terms. Some contracts allow the vendor to fill unused space with detainees from other jurisdictions, reducing the requirements for additional facilities. The INS has shared bedspace with the U.S. Marshals Service and the Bureau of Prisons at several of its contract detention facilities.

The use of contract detention facilities is a technique for transferring some detention activities from the Government agencies to the private sector. This is an effective means to maximize the resources available to the INS.

B. Solicitation History - Why ESMOR Was Awarded the Contract

In June 1992 INS Headquarters Office of Contracting and Procurement produced a solicitation package for the procurement of a 300 bed detention facility in the New York/Newark area. The procurement package contained a Statement of Work (SOW) provided by HQDDP. This SOW was developed to be the national guideline for INS detention facilities.

The solicitation was advertised in the Commerce Business Daily in September 1992. The request for proposals were due and received on December 14, 1992. The award was predicated upon a combined technical and price formula scoring. In determining the overall score for each proposal a technical committee reviewed the submissions and provided their evaluations of the contractors strengths and weakness to the Administrative Center Burlington (ACBADM) Regional Contracting Officer. The contractors were given the opportunity to address the areas of concern and provide a revised technical proposal. The technical team re-evaluated the proposals and provided their assessments on March 5, 1993. Oral discussions were conducted on *price and technical issues* and Best and Final Offers (BAFO) were requested from each contractor. The technical committee evaluated the BAFOs and provided the final technical score to the ACBADM Regional Contracting Officer.

ESMOR received a total of 145 out of a possible 200 points for their specific technical approach. The price proposals were evaluated by ACBADM utilizing price analysis techniques in determining the price reasonableness of the contractor's proposals. The contract was awarded to ESMOR New Jersey Inc. in August 1993 for a base year amount of 9.3 million dollars. The term of the contract was for a one year period beginning August 3, 1994 plus four one year option periods.

C. Why Was the Facility Built?

The INS determined that a substantial increase in recent years of malafide applicants (principally asylum seekers without a credible claim) at both John F. Kennedy International Airport (JFKIA) in New York City and Newark International Airport (NEWIA) in Newark, New Jersey was directly related to the inability of the INS to detain these persons. As part of an overall effort to better control our borders and discourage illegal immigration, the INS issued and awarded a contract to build and operate a 300 bed detention facility to hold aliens attempting unlawful entry at JFKIA and NEWIA.

Prior to the opening of the ESMOR detention facility, the New York District was releasing an average of 650 to 700 aliens per month from JFKIA. Since the opening of the ESMOR facility and the increased availability of bedspace, releases at JFKIA and NEWIA, caused by the lack of bedspace, are believed to have sharply decreased. Exact release figures were requested but not received as this report is written. The number of applicants for admission in the New York District,

who were inspected by INS and determined to be malafide, dropped from a high of 14,000 cases per year to 7,000 cases in Fiscal Year 1994.

D. Location and Description of Facility

The ESMOR detention facility is located in a warehouse district in Elizabeth, New Jersey, within the jurisdiction of the INS Newark District. The facility is rated for a total of 300 detainees. There is sufficient square footage throughout the facility to support a daily population of 300 detainees and an emergency population of 327 detainees. At the time of the disturbance, INS was maintaining an average of 300 detainees in the facility; with 315 on the day of the disturbance. Persons detained at the facility were chiefly aliens who were placed under exclusion proceedings when they attempted to enter the U.S. at JFKIA or NEWIA with fraudulent documents or no documents. Many of these detainees were applicants for asylum who did not make a credible asylum claim to INS.

The facility contains several dormitory style sleeping areas with adjacent day rooms. Each dormitory has appropriate restroom facilities for use by the detainees. Male and female dormitories are separated in a manner which provides for privacy between genders and is designed to prevent viewing from unauthorized areas. In addition to the dormitory areas, the facility is equipped with support service areas which include a full service medical clinic, full service kitchen preparation and cleaning area, recreation areas (indoor and outdoor), a law library, and a laundry area.

III. Assessment of ESMOR Operations

The following areas were addressed during the review of ESMOR's operations:

As part of the overall assessment of ESMOR, the Assessment Team reviewed operations, support programs within the facility, and ESMOR's ability to identify and deal with day-to-day problems. Additionally, ESMOR's ability to interact and communicate with INS and the Executive Office for Immigration Review (EOIR) was evaluated based on concerns of the District, Eastern Region Detention and Deportation (RODDP), and Headquarters prior to and during the assessment.

The Team reviewed other problem areas as necessary. Two assessment visits were conducted; the first on June 7 through June 10 and again after the disturbance of June 18. The Team evaluated complaints from the office of Congressman Robert Menendez, and those provided by *pro bono* attorney groups, and featured in news media accounts concerning ESMOR. Additional complaints that were provided to the Assessment Team during the review by detainees and facility staff were also investigated.

A. Detainee Welfare

The INS has made clear its profound commitment to hold alien detainees only in conditions that are humane, safe, and secure. This commitment extends to all detention settings, i.e., INS Service Processing Centers, local jails, and contract detention facilities. Inhumane actions by personnel responsible for the detention of aliens, or actions which are clearly detrimental to the welfare, safety, and security of detainees, are insupportable and totally unacceptable to the INS.

The Assessment Team conducted interviews with 24 detainees, five attorneys, various ESMOR guards, ESMOR Management and INS personnel. From these interviews the Assessment Team discovered that detainees were subjected to harassment, verbal abuse, and other degrading actions perpetrated by some ESMOR guards. There were allegations of physical abuse perpetrated by a small number of ESMOR guards. Of particular concern were the number of complaints regarding maltreatment of detainees by ESMOR employees working the midnight shift. The Assessment Team found that complaints of verbal abuse and general disrespect by ESMOR personnel towards detainees, visitors, and attorneys were credible and that such actions were common on all shifts. The complaints referencing physical abuse typically focused on actions by midnight shift employees The Assessment Team concluded that these occurrences were not caused by uncontrollable or spontaneous anger on the part of ESMOR guards. Rather, the evidence suggests that these incidents were part of a systematic methodology designed by some ESMOR guards as a means to control the general detainee population and to intimidate and discipline obstreperous detainees through the use of corporal punishment.

Several attorneys reported to the Assessment Team that detainees were being harshly treated. These attorneys, Stephanie Marks, Joyce Phipps, Carmen Mendiola, and Gloria Alfonso stated that during visits to ESMOR they had observed visible marks and bruises on some of the detainees whom they represented. Further, these attorneys said it was not uncommon for them to see detainees pushed up against the wall and treated roughly by contract guards in other ways.

In addition to the available direct evidence of the attorneys, the Assessment Team was able to locate a relevant witness who has provided specific information, as part of an ongoing criminal investigation, concerning many other allegations of abuse. However, various other ESMOR employees simply refused to talk candidly to Assessment Team members out of fear of retaliation or potential prosecution. Others were conveniently unavailable. Still others were clearly less than candid. The following are some examples of abuses reported to the Assessment Team.

Example 1: In post-disturbance interviews female detainees reported that they had been issued male underpants. On these underpants, which were generally too large, a large question mark had been made in the area of the crotch.

Example 2: Detainees reported that on numerous occasions specific ESMOR personnel refused to issue sanitary napkins to female detainees who were menstruating.

Example 3: Detainees and attorneys reported that, in contravention of facility policy, ESMOR guards frequently awakened detainees in the middle of the night, often several times per night. This was done on the pretext of conducting head counts and/or security checks. The true motive manifestly was to harass the detainees. When INS officers at the facility were made aware of this abusive behavior through interviews with detainees, they insured it ceased immediately.

Example 4: Theft of detainee property by an ESMOR guard was reported. The INS Assessment Team immediately notified the Office of the Inspector General.

Some of the detainees interviewed were unwilling to provide sworn statements because they feared retaliation. Nonetheless, the Assessment Team found the complaints to be credible and has requested that the Office of Internal Audit (HQOIA) assist with a follow-up investigation. Although no formal allegations of abuse have been filed at this time, HQOIA is pursuing leads that were developed during the assessment. HQOIA will continue to independently investigate, beyond the completion of this report, any additional or unresolved claims or allegations that come within its jurisdiction. The Federal Bureau of Investigation (FBI) has initiated a Civil Rights Investigation to determine if any prosecution is warranted for civil rights violations. The primary focus of the FBI investigation will be ESMOR guards who may have acted in violation of Federal law. Other local law enforcement agencies are reviewing the disturbance for possible prosecution.

As indicated earlier, some ESMOR employees whom the Team interviewed expressed fears that cooperation with investigators would make them vulnerable to job termination and possibly criminal prosecution. It was discovered that some ESMOR mid-level supervisors and guards specifically cautioned their colleagues of the need to remain silent when questioned by members of the Assessment Team. This was referred to in at least one employee muster as "maintaining the blue

wall" (a term sometimes attributed to law enforcement officers, to connote their intention to withhold information from investigators). Nevertheless, the investigation by the Assessment Team uncovered the identities of those ESMOR guards principally responsible for the maltreatment of detainees. The abuser group consisted of five guards and two guard-lieutenants. Six were removed from the contract, terminated, or allowed to resign by ESMOR. These cases are being examined by INS Office of Internal Audit for possible prosecution. The seventh guard was identified as a participant in a single instance of what some characterized as "non-serious harassment." This took place prior to June 18. The facts of the incident did not sustain a probative finding of harassment. The exact incident was murky and conflicting information was presented by witnesses. It is clear that the incident involved only a short verbal confrontation between the guard and a detainee, and the situation was quickly suppressed by other ESMOR guards who separated the disputers.

Based on an overall review, and confronted with the types of misconduct noted above, the Assessment Team concludes no real control was exercised over ESMOR guards by their mid-level supervisors. While the abuse and harassment of detainees happened at hands of a small group of ESMOR guards, and usually during the night shift after facility managers had left for the day, this does not exculpate ESMOR management from responsibility for the actions of its employees.

Recommendations:

a. ESMOR should be required to submit to the INS for review and approval a policy and procedure which describes what steps will be taken to notify the INS COTR of any incidents which involve a detainee. Some examples are:

- assault by a detainee on an ESMOR employee (or vice versa) or other detainee.

- incidents requiring placement of detainees in segregation.

- incidents requiring the use of non-routine restraints inside the secure perimeter of the facility, i.e., combative detainees, precautionary due to threat of violence etc

- incident, or complaint by detainee, alleging misconduct by ESMOR personnel. All incident reports are to be followed with detailed investigations and conclusions as well as identification of disciplinary action taken where complaints are proved.

b. ESMOR should be required to provide INS copies of complaints made against ESMOR employees. They must include complaints by the general public, attorneys, or other private or public interest groups. This would apply to complaints concerning treatment of detainees and/or conditions of confinement. ESMOR must also provide

to the INS COTR for his follow-up, a copy of their response if any, and a report of what actions they took to resolve the complaint.

B. Policies / Practices / Emergency Plan

Deficiencies related to policies, practices, and the emergency plan were found during the review of the ESMOR facility and operations.

Policies:

On March 17 RODDP was advised by Officer Norman Uzzle, the INS COTR (the Contracting Officer's Technical Representative is the on-site person who monitors contractor compliance with the contract), that ESMOR had initiated a practice of using leg restraints on every detainee as a means of preventing escapes during visitation and court hearings. Uzzle notified RODDP by faxing them a March 16 newspaper article that outlined the practice. On March 23, ESMOR was notified by INS' Administrative Center Burlington (ACBADM), which administers the ESMOR contract, to cease this practice. The reason for the delay in issuing the notice was that ACBADM had to await an investigation of the incident.

During April, RODDP was notified by Officer Uzzle that ESMOR management had initiated a practice of charging aliens for lost items which ESMOR is required to supply under the terms of the contract. Examples of these items were eating utensils, clothing, drinking cups, etc. Officer Uzzle only became aware of this situation when he discovered a memo notifying the detainees of this practice. ESMOR was requested to provide information to ACBADM regarding this practice. ESMOR responded by rescinding the policy.

Another serious policy violation was alleged during a confidential interview with an ESMOR guard. The guard revealed that placement of detainees into segregation without a charging document was a frequent occurrence. This would be a violation of ESMOR's policy and procedures as well as the standards of the American Correctional Association (ACA) which INS requires contract detention facilities to follow (although the facility is only required to "seek ACA accreditation" within nine months of opening). According to the interviewed guard, the segregation unit was used as a means both of punishing detainees for relatively minor offenses, and for more general harassment. This activity took place primarily on the night shifts. Similar unsolicited charges were made by various attorneys interviewed by the Assessment Team. Attorneys further charged that when an attorney would question the placement of a detainee into segregation and demand an explanation, the attorney would be denied this information by ESMOR managers. Significantly, however, the detainee would quickly be released back into the general population. The credibility of these charges was validated when on June 14 Officer Uzzle notified ESMOR that he had found, in the segregation unit, a detainee who had no offenses listed on his information sheet.

The Assessment Team cannot, without further review and detainee interviews, determine the scope of this practice. ESMOR advised the Team that disciplinary files were destroyed during the recent disturbance. Thus, it is virtually impossible to provide any documentation regarding which detainees received a disciplinary panel hearing. Further detainee interviews, which may provide additional information, are being conducted by INS Special Agents in the Philadelphia District where the aliens are currently detained. The results of these investigations were not available as this report was written.

Practices:

Missed flight and missing property -

Aliens who had been served with a final notice for removal and for whom departure arrangements had been made often missed their flights. This was generally due to two specific causes. First, early in the contract period, ESMOR personnel often missed flights or forgot to deliver aliens to the airport. Corrective action was taken to better coordinate airport turnarounds and removals from the facility. Second, ESMOR personnel attempted to deport aliens without returning their funds, valuables, and property; a clear violation of both INS' and ESMOR's policy and procedures. Many aliens, properly, refused to get on aircraft without their funds and valuables. They were returned to the facility. Where the delays caused by this procedure resulted in additional man-days being charged to the INS, appropriate deductions were subsequently made by the INS COTR.

Through a review of the INS COTR's files, the Assessment Team found this continued to be a problem even though ESMOR had been notified by the COTR in May that corrective action was needed.

Policy changes without notification -

The INS Assessment Team found that ESMOR demonstrated a pattern of initiating changes in policy without prior notification to the INS via its COTR, as required under the contract. This practice of modifying existing policies and/or implementing new ones without properly notifying INS or receiving INS concurrence materially hindered INS' ability to effectively perform its oversight functions. Moreover, some of the decisions made by ESMOR had a serious negative impact upon relations between the INS and the general public since, in the public perception, INS is inextricably linked to the operations of the Elizabeth facility.

Emergency Plan:

The Assessment Team made a preliminary review of the ESMOR facility emergency plan and its implementation. The Team interviewed Mr. Willard Stovall, ESMOR Facility Administrator, and Officer Michael Rozos, INS Officer in Charge at the Facility. The facility emergency plan was

reviewed for comment, prior to the opening of the facility, by INS representatives from the Newark and New York Districts. Recommended changes were given to ESMOR for incorporation into a final policy. There is no evidence of any follow-up by the Newark District to see if any of these changes were incorporated.

The Assessment Team found that a serious contract deficiency exists, in that there is no requirement in the contract for INS to approve policies and procedures for this detention facility; including the emergency plans. Even so, ESMOR did not properly implement the plan when needed. ESMOR personnel were either poorly trained in or unaware of the policy and procedures contained in the emergency plan. The Assessment Team found that Newark District did not properly monitor ESMOR's training for emergencies throughout the contract period to ensure a proper level of competence in the guard staff.

Numerous elements listed under ESMOR Policy 8-1 as factors which may contribute to a riot were extant in the facility prior to June 18. ESMOR was aware of the existence in the facility of circumstances listed as warning signs in their policy, having been so informed, along with INS staff at ESMOR, by members of the Assessment Team during the period June 7-10. Those elements identified by the Assessment Team were:

1. Complaints about food.
2. Dissatisfaction with certain staff.
3. Complaints about medical treatment.
4. Complaints regarding privileges.
5. Any large increase in detainee complaints (as featured in disciplinary reports).
6. Misinformation relayed to detainees.

Additionally, the Assessment Team reminded both ESMOR and INS staff that conditions existed that were also later identified as being part of ESMOR Policy 8-1. The plan includes the following caution: "Prompt detection and reporting of a bad climate within the detention facility may allow timely changes and avoidance of incidents that could lead to riots. Indicators might be a detainee's sullen, restless, easily excitable behavior and his avoiding contact with employees."

The Team found that, in large degree, the failure of the policy and procedures was attributable to the lack of training and experience in the case of most of the ESMOR guards. The deficiency in the amount of guard training added to the already volatile environment. Moreover, many of the guards had no actual experience in the detention and handling of people. Faced with an emerging disturbance, the employees adopted an every-person-for-himself mentality and fled the facility.

The Assessment team has further reviewed procedures which are outlined in the emergency plans under "Steps to be Taken" page 3 of Policy 8-1, ESMOR Emergency Plans. As outlined under

the procedures, the facility riot plan should have been promptly activated in conformity with the following:

1. Containment of Rioters:

   a. Staff should take immediate steps to secure any avenue of escape
   b. All areas should be secured to localize and prevent the disorder from spreading
   c. Assessment of the situation should be made prior to committing staff which could result in their being taken hostage.

However, the Assessment Team concluded after interviews of ESMOR personnel and Officer Uzzle that ESMOR guards did not take any steps on their own to prevent escape or secure the perimeter. ESMOR guards took no action to prevent the disorder from spreading. Guards withdrew from the facility and took no action other than to call the local emergency services via 911. Furthermore, the ESMOR duty supervisor failed to take appropriate steps which would ensure ESMOR staff and innocent detainees were not placed in undue jeopardy. The Team concluded that the duty supervisor followed no procedure to account for personnel under his charge, and ensure that all personnel departed the facility. ESMOR staff further failed to properly evacuate and remove female detainees who were clearly not involved in the initial disturbance. Their failure to respond appropriately to this emergency and follow ESMOR policy directly caused one female guard to be taken hostage and placed the female detainees in potentially life-threatening circumstances.

The Assessment Team concluded that the duty supervisor made a serious error in his decision to order an evacuation of guards under the existing circumstances. Moreover, his decision was not made in conformity with ESMOR Policy 8-1.

INS Response Force

Within the ESMOR Emergency Response Policy (8-1), reference is made to an INS response force. Within the Newark District, there is no approved INS Emergency Response Force or Team. What does exist is simply an ad hoc identification of appropriate personnel. including Special Agents, Detention and Deportation personnel and other INS enforcement personnel, who may be contacted during an emergency. The Assessment Team found no evidence of any specialized training performed within the District which would prepare these personnel to work as a single unit in the event of an emergency at ESMOR.

Availability of Plan to Emergency Services

In statements and reports published in the news media immediately after the disturbance, City of Elizabeth, County, and Emergency Services officials claimed that ESMOR and INS had failed to provide necessary emergency plans and information related to the facility.

The Assessment Team found that prior to the opening of the facility, ESMOR and INS officials met with City of Elizabeth Emergency Services personnel. These meetings included the Fire and Police Departments. Then ESMOR Facility Administrator, John Lima, provided physical plant plans and tours of the facility. Additional tours were provided to Special Weapons and Tactical Team representatives as a means to acquaint them with the facility, in case their services were ever needed. Subsequent meetings with local officials were held periodically throughout 1994. Both Mr. Lima and Officer Rozos verified that these meetings had taken place as characterized above. Copies and documentation referencing these meetings have been requested. The Assessment Team concludes that ESMOR and INS did establish appropriate liaison with local Emergency Services entities and provided them with sufficient information upon which to safely and effectively respond to an emergency at the ESMOR facility.

Recommendations:

a. ESMOR should be required to notify the INS COTR in writing of every change in policy and procedures subject to the contract.

b. INS should physically inspect the segregation unit daily.

c. INS should require ESMOR to develop and implement a sound transportation policy which ensures that aliens depart on scheduled flights with all property, funds and valuables, as required under the contract.

d. ESMOR must provide tighter controls over the processing, storage, and accounting of personal property. ESMOR needs to develop an auditable procedure for assuring the proper safeguards of all detainee property.

e. The contract should be modified to require that INS more closely monitor the quality of ESMOR training.

f. The District should develop an emergency response plan to react to emergent situations at the facility.

g. Require formal INS approval of all contract policies and procedures.

C. Reporting and Internal Controls

The Assessment Team found that because of a longstanding ESMOR practice of keeping information from INS, the Service had little knowledge of specific problems or concerns of detainees the custody of ESMOR. The Facility Administrator, Willard Stovall consistently referred to the facility as "my house" in a manner indicative of his apparent belief that INS should not participate

in day-to-day matters related to detainees. The Assessment Team determined that the strained relationship between the INS COTR and Mr. Stovall was chiefly due to ESMOR's failure to provide INS COTR Uzzle with vital information and, its unresponsiveness in taking timely required corrective actions. This finding is supported in memoranda provided to the Assessment Team by Officer Uzzle. At the time of the assessment, there was no sign of any sort of partnership between ESMOR and INS in the operation of the facility. Regular and timely communication between ESMOR and the INS was nearly non-existent.

As reported to the Assessment Team by Officer Uzzle in person, followed by his memorandum, "One evening late in May or early June, I was having a conversation with ESMOR's Facility Manager, Willard Stovall. In that conversation he stated that it was ESMOR's Corporate policy to keep INS in the dark as much as possible about any problems or incidents which occurred with regard to the facility, i.e., ' if INS doesn't ask for it, don't volunteer or give them anything.' Before Mr. Stovall made this statement, he stated it was 'off the record."

It is clear that Mr. Stovall was well aware of the practice of withholding information from the INS. For example, ESMOR routinely failed to notify the INS COTR of the terminations and resignations of ESMOR staff. ESMOR is not required under contract to notify INS of the specific reasons why employees are removed from the employee roster, however, ESMOR must notify INS of the date each person leaves and the name of the departing employee. Furthermore, staffing information provided to the Assessment Team by ESMOR did not match names on daily schedules. Prior unsuccessful attempts, on at least three documented occasions, by ACBADM and RODDP to obtain accurate employee records from ESMOR resulted in remedial action by the Region to remove from the facility ESMOR guards who had not received the proper security clearance.

The Assessment Team concluded that ESMOR commonly failed to provide, and in some instances withheld from INS, access to important information regarding daily operations and problems in the facility.

Recommendations:

a. ESMOR should provide to INS all incident and disciplinary reports on ESMOR personnel. If necessary, the contract should be modified to reflect this to ensure compliance. (Re: In terminations, suspensions, and any other personnel actions taken, the finding must be reported) Through this procedure INS would have had a much clearer picture of contract employee behavioral problems.

b. The contract should be modified to allow the COTR more direct authority to intervene in practices which may adversely affect the INS. Four days is an unacceptable period of time to wait for corrective notices.

D. Staffing and Personnel Issues

Staffing Inadequacies:

The staffing levels at the ESMOR facility were determined by the technical proposal submitted by ESMOR and accepted by the Government. Their proposal stated that the facility required 127 full time equivalent (FTE) employees to operate on a 24 hour basis. It should be noted that ESMOR was only required to meet the number of FTEs they proposed, while the actual number of staff on their payroll was left to ESMOR's discretion. It is noted throughout this assessment that ESMOR utilized excessive amounts of overtime in order to meet the requirements of their proposal.

The Assessment Team noted that excessive overtime, a high rate of employee turnover, and new background investigation requirements protracting the time period for obtaining clearances were factors in creating a shortage of ESMOR guards. Over the course of the facility's operation, ESMOR increasingly relied on overtime to compensate for staffing shortages. Approximately two months ago, ESMOR accelerated a practice of "double-shifting", i.e., requiring employees to work two consecutive eight hour shifts. The Assessment Team found, based on statements by ESMOR Facility Administrator Willard Stovall , that this was done in order to cover mandatory posts. Mr. Stovall conceded, after presentation of the facts by the Assessment Team, that ESMOR did not have sufficient personnel and was covering the deficiency with large amounts of overtime.

During the assessment, ESMOR personnel were routinely observed at locations other than their assigned posts. On three separate occasions during the assessment, the main entrance post (a two-person post) was understaffed. The single guard on duty (not the same person in each instance) was visibly frustrated. In another instance, people entering the facility were setting off a metal detector while the ESMOR guard assigned to monitor the device was at the coffee wagon outside the door. The metal detector is a principal deterrent to prevent the introduction of weapons or contraband into the facility.

Recreation was often supervised by having either the roving guard maintain a stationary post or by having the nearest dorm guard provide for both recreation and dormitory security. The result was that some housing units were left unsupervised.

Officer Uzzle and Officer Boyer, Acting Officer In Charge, reported that within hours of the departure of the Assessment Team from Newark, they observed some ESMOR guards leaving their posts unattended or in the process of leaving them unattended until they realized they were under observation. These discrepancies were noted and the Regional Contracting Officer was notified.

Population Level in Facility:

In March the facility population was reduced by INS due to concerns by ACBADM and RODDP that ESMOR was unable to perform adequately at a population level of 300 detainees. One

of the Region's concerns was that the facility was under-staffed and ESMOR seemed unable to provide an appropriate level of staffing or was unwilling to devise a strategy to maintain the appropriate minimum staffing level.

In April after ESMOR demonstrated that its personnel had received security clearances, and after problems had been addressed concerning the excessive number of escapes (27 between August 3, 1994 and January 15, 1995), excessive medical referrals (noted by Public Health Service), and training issues, INS once again permitted an increase in the facility population.

Staffing During the Disturbance:

At the request of the Assessment Team, RODDP reviewed documentation detailing ESMOR staffing for two consecutive eight hour shifts on June 18, the night of the disturbance. RODDP found that nine of the 13 ESMOR guards on duty were in their second consecutive eight-hour shift. This is particularly significant in view of the fact that several days before the disturbance INS Regional and District officials had begun actively considering lowering the facility population by the transfer of 75 detainees. This action was under consideration because of concerns over ESMOR's inability to properly staff the facility without requiring guards to work double shifts. On the Friday afternoon before the disturbance, INS notified ESMOR that 11 guards could not work due to lack of suitability waivers. In response to this notification, ESMOR assured INS District officials that a sufficient number of guards were available to work the weekend shift without compromising the staffing requirements or negatively impacting security.

ESMOR knew, or should have known, of its inadequate staffing situation and how hazardous it could be to continue to operate in that mode. Additionally, ESMOR reasonably should have known, and properly responded to, the expected decrease in staff efficiency that must inevitably result when staff are required to work double shifts over a extended period (in this case, for months).

It is the finding of the Team that, based on existing knowledge of ESMOR staffing practices, the Newark District and RODDP did not exercise due caution in verifying ESMOR's claim that they had available, and had assigned sufficient staff to cover the facility on the weekend of June 17-18.

Recruitment of Guards:

A problem cited by ESMOR was recruiting qualified personnel to perform the duties in the facility. The Assessment Team has requested Newark District to conduct a review of current personnel records (provided by ESMOR) to verify what qualifications staff members had for security positions involving the detention of aliens or persons in custody. ESMOR's failure to recruit sufficiently qualified applicants and to dismiss questionable or marginal personnel, was a contributing factor in the abuse of detainees. ESMOR failed to provide a recruiting plan that addressed its staffing problems in a realistic manner. According to the records of Administrative Center Burlington Office of Security (ACBSEC), this facility has an approximate personnel turnover

rate of 60 percent. ESMOR should have addressed its serious labor problem in a more responsible manner.

Classification and Salary of Guards:

Contract guard positions required under the contract are defined by the Department of Labor as "Security Guard II" for minimum salary determination. It appeared that this salary level did not support an adequate level of qualified applicants to operate the facility.

The duties and responsibilities of a guard in a detention setting are closely analogous to those of a Correctional Officer or Detention Enforcement Officer. The "Security Guard II" position relates more closely to a guard in a warehouse. In brief, the "Security Guard II" standard related more to one who guards "things", where ESMOR obviously needed guards who deal with people as well as things. The typical warehouse guard does not earn a wage that is as high as a guard who is also responsible for the welfare and security of persons.

ESMOR's salary structure was adopted as part of their competitive pricing strategy. As such, it was responsible in part for ESMOR being awarded the contract. However, it appears that the level of salary was not realistic and could not, in the area where ESMOR is located, ensure the availability of well qualified applicants. It is evident that many, if not most, of the guards hired by ESMOR did not meet the requirements of the contract or were only marginally qualified. In the end, they proved unable to maintain control of the facility or ensure detainee and facility safety and security.

Mr. Willard Stovall ESMOR Facility Administrator told the Assessment Team that he was unable to replace a number of undesirable employees because ESMOR did not have a pool of qualified applicants from which they could draw immediate replacements. Several of the undesirable employees were later identified as guards who were suspected of abusive behavior toward detainees.

Security Clearances:

Evidence indicates ESMOR employed individuals as guards in the facility after merely submitting their investigative paperwork to INS. This resulted in uncleared guards working in the facility and was another reason why the detainee population was reduced in March. The contract clearly states that this practice is not permissible. This practice should have been detected and prevented by the COTR and the Regional Security Officer. ESMOR was told to cease this practice in March, after ACBADM, RODDP, and ACBSEC compared ESMOR employment records against ACBADM security records. This problem was corrected before the population level was restored. In June a list of personnel approved by Security was again compared to a list of personnel on the job site. The comparison, performed by Eastern Region Detention and Deportation (RODDP) and Administrative Center Burlington Administration (ACBADM), once again showed numerous

uncleared personnel were on duty at the facility. Before INS could take specific action to correct this situation, the June 18 disturbance intervened.

The process and procedures for requesting and approving security clearances were seriously flawed at all levels including the ACBSEC, the District, and ESMOR. The error rate of investigative forms received from ESMOR by the Regional Administrative Center Security Officer (ACBSEC) was unacceptably high. Nearly every investigation was delayed by days if not weeks for corrections. INS and ESMOR share some of the responsibility here, for if the proper procedure had been followed, the completed forms should have been reviewed and corrected by ESMOR and the COTR prior to being received by the ACBSEC. This would have resulted in a much lower error rate and significantly decreased processing time.

The ACBSEC forwarded fingerprints to the Headquarters Office of Security (HQSEC) by regular mail. This process took as long as seven days in some cases. Furthermore, there was no consistency in the manner for which waivers were granted, and follow-up by the ACBSEC and the COTR was poor.

On two separate occasions, RODDP and ACBADM intervened and removed numerous ESMOR personnel from the facility as a direct result of the failure of ESMOR to obtain the appropriate security clearances for its employees. On those occasions, the Region was unable to obtain an accurate list of current employees from ESMOR and similarly unable to obtain an accurate list of cleared applicants or employees from the ACBSEC. As a result, those employees working at the facility and for whom no security clearance had been granted, were ordered off the site until the appropriate security clearance was obtained.

Recommendations:

a. ESMOR must provide satisfactory written evidence of appropriate staffing levels to INS under the terms of the contract. An INS review should be conducted monthly for the life of the contract to ensure compliance with minimum staffing requirements set out in the contract.

b. INS should require ESMOR to provide an exact staffing plan for detainee populations of 200, 250, and 300 before the facility is reopened. These staffing plans should be monitored, and ESMOR should be required to comply with reporting requirements including, but not limited to, notifications of personnel on staff, suspensions, and terminations. If necessary the contract should be modified to reflect this change.

c. Newark District should more closely monitor the facility population level and, with Region, act more quickly to reduce the population level when necessary.

d. The contract should be modified to reflect the necessary classification change in the guard series, to attract better qualified applicants.

e. Newark District/Region should exercise increased vigilance to ensure all ESMOR on-duty staff have proper clearances or waivers.

f. Based upon the past performance of the Security Officer and the lack of confidence expressed by RODDP, HQSEC should continue its review and assessment of the Administrative Center Burlington Office of Security and, if necessary, institute systemic improvements.

g. Remedial training or hands-on informational training should be provided to ensure there is no repetition of problems utilizing the security clearance procedures.

E. Training

Under the terms of the contract, ESMOR is required to provide a minimum of 40 hours of orientation and basic training to all employees prior to placement on the job. All newly selected ESMOR security personnel are required to complete a minimum of 160 hours (including the 40 hours noted above) of training within the first year of employment. The Assessment Team made the following findings based upon memoranda and charts obtained from ESMOR management, ESMOR personnel files, and INS Regional records.

Prior to the opening of the ESMOR facility, a comprehensive training program was initiated using a curriculum reviewed and approved by the then INS COTR Officer Michael Rozos. The curriculum as presented exceeded the requirements by eight hours for a total of 168 hours during the first year of employment for all security personnel.

ESMOR records indicate training was provided as required to employees hired in June, 1994 (the facility was opened August 3, 1994). There were no trackable records to indicate ESMOR complied with the contract requirement after the initial training session was provided. Therefore, the Assessment Team requested a full review of facility personnel files to determine dates when personnel entered on duty and whether or not they received the required training.

This review determined that ESMOR was assigning personnel to security assignments without meeting any minimum training requirements. The last known training session according to ESMOR records was held from March 23 through March 27. The Assessment Team found that the training class was scheduled by ESMOR only after INS discovered approximately 32 percent of the security personnel assigned to ESMOR did not have the required security clearance, and informed ESMOR that they could no longer use these personnel inside the facility. ESMOR took this opportunity to provide them with the initial required training. Fourteen ESMOR personnel

received training at that time, consisting of forty hours of orientation and basic training required for new employees. Of the 14, all had been employed as security guards with the company at least two months. Ten had been employed in or prior to November 1994. This was a violation of the contract's requirement that all new personnel must receive forty hours of orientation and pre-employment training before being assigned to a duty post. Furthermore, there is no evidence of any type of on-the-job training (OJT). While OJT is not specifically mentioned in the contract, it is common for new employees to receive training and some type of review by supervisor or senior employee to ensure they understand how to apply any training they have received.

The Assessment Team questioned ESMOR Facility Administrator Willard Stovall regarding how many on-duty personnel had not received the appropriate training. Mr. Stovall admitted that he currently had four persons performing security duties who had not received the required training. Mr. Stovall said he was expecting more new hires and desired to present the training to a single group.

A certain level of interpersonal skills are essential for anyone dealing intimately both with a detained population and the public. The attitude of many ESMOR personnel towards visitors, attorneys, and the Assessment Team brought into question the effectiveness of their training in this area. An incident took place prior to June 18 that is an example of the prevailing lack of interpersonal skills among many ESMOR guards. The incident involved local Elizabeth City Councilman, Mr. Orlando Edreira, who was requested by INS to meet with the Assessment Team at the ESMOR facility. It was clearly explained to the ESMOR guard standing post in the reception area that Councilman Edreira would be coming to meet with INS officials. Still, when the Councilman arrived, the guard refused him access. Councilman Edreira had presented the guard with unquestionable proof of his identity, i.e., valid city credentials, including a badge. He clearly stated his business, and that he was there by invitation of INS. The guard, having denied the Councilman entry, did not then take the customary and appropriate action of notifying INS that a city official was in the reception area. As a result of the guard's inexplicable intransigence the INS Assessment Team was unaware of the Councilman's arrival. The guard's actions created an unnecessary embarrassment for the Service, and served to anger and alienate a city official whose good offices are of importance in securing INS interests in the community.

ESMOR management should reasonably have been able to deduce, by the number of complaints received from visiting attorneys and the general public, that there were serious problems in the area of staff to detainee and staff to public relations. ESMOR should have addressed this through remedial training.

It is the finding of the Assessment Team that ESMOR did not comply with the standards of training as outline in subsection three of the contract in that, the contractor is required to provide a minimum of forty hours of INS approved training prior to assigning an employee to any post. As indicated above, ESMOR failed to do so in numerous cases. Additionally, ESMOR is required to provide a total of 160 hours of total training during the first year. ESMOR did not have sufficient

personnel resources to accomplish the required training without adversely affecting its ability to properly man posts within the facility.

Recommendations:

a. ESMOR should be required to submit proof of a comprehensive training plan which ensures that all ESMOR personnel will receive the appropriate amount of training and orientation in a timely manner.

b. ESMOR should be required to submit a monthly report detailing the amount of training, type of training provided, and names of employees receiving the training.

c. The INS COTR must more closely monitor the ESMOR training program and records to ensure the accuracy and completeness of the information provided by ESMOR.

F. Food Service

Food Service is provided via a full service food preparation area located on-site. Food service responsibilities are sub-contracted by ESMOR to Aramark Food Service Corporation. Detainees are provide three meals each day at regular intervals. A total average caloric intake of 3,300 calories per day is provided to the detainees. This is in excess of the contract requirement. The food is prepared on-site and delivered to the dormitories in an appropriate manner. Menus and daily diet requirements are certified by a registered dietician, as required in the contract, to ensure that daily nutrition requirements are met. Additional commissary food items are available for a nominal charge.

The Assessment Team examined food preparation and storage, including verifying that proper temperatures were maintained. Food related implements, equipment, and machinery were examined (including partial disassembly) to check for cleanliness. The Team found all physical components of food preparation. service. storage. and disposal to be adequate or more than adequate.

There were numerous detainee complaints about the food. Primarily, the complaints centered around the actual preparation, variety, and taste of the food. Some detainees complained the food was too spicy and caused stomach aches. They also complained that when they advised ESMOR personnel and management of this, ESMOR responded by providing more food but did not address the preparation and taste issues.

The Assessment Team found no spoiled food or canned food with expiration dates exceeded. The Assessment Team determined that ESMOR was unresponsive to the detainees request to change the menu or the manner in which the food was prepared. The detainees often responded by refusing

to eat the meal and throwing it away. With the number of complaints generated during the assessment, ESMOR management should have addressed this issue in a more aggressive manner. However, it is noted that most on-duty ESMOR staff and many on-site INS staff availed themselves, for a modest charge, of the opportunity to eat at the facility. They ate exactly the same food as the detainees. The Assessment Team sampled a meal at the facility and found the food palatable and acceptable.

Recommendations:

a. ESMOR and INS should create a system to more closely monitor detainee complaints about food, determine if the complaints have merit, and provide the detainees with specific responses.

G. Medical Care

At the request of INS RODDP three medical assessments of the facility were conducted within the last five months. RODDP was concerned that the facility was making excessive medical referrals to emergency rooms and other outside medical services.

Two assessments were conducted in February. One by a team from the INS Health Services Division (HSD) administered by the Public Heath Service (PHS). The other by Doctor W. Cheung, PHS Clinical Director, Varick Street Service Processing Center Medical Clinic. In May, Doctor Cheung also conducted a follow-up assessment. The following are the findings of those assessments.

Findings of February Assessment by HSD Team:

1. Inappropriate referrals for off-site medical care of cases that could and should have been treated in the facility's clinic. Under the contract, off-site medical care expenses are chargeable to INS not ESMOR.

2. Lack of documentation in the health care record with regard to treatment rendered and necessity of off-site referrals.

3. Referrals to dental without documented assessment and need for referral.

4. PPD screening (Purified Protein Derivative-the standard medical test to screen for tuberculosis) for tuberculosis was not consistent and some detainees were not properly screened.

5. Health appraisals were not being carried out on all detainees within 14 days as required by the contract. (In one case a detainee had not received a medical screening until four months after he was booked into the facility)

6. The progress notes in all cases were that of an RN. The notes indicated the condition of the detainee, but contained no objective information, assessment, or treatment plan. No follow-up appointments were noted in the record.

7. Follow-up with regard to off-site care was not documented except in one or two instances. This documentation was that of an RN indicating that the Designated Health Authority had reviewed the findings.

8. Follow up with regard to laboratory work, x-rays, on-site dental work or serious medical conditions was not documented.

9. While off-site and laboratory referrals were appropriate in some instances (e.g., eye problems, enlarged testicles, blood in stool), the majority of records contain no documentation supporting the referral for off-site care.

Findings of February Assessment by Doctor Cheung:

1. The facility had 12-hours-per-week physician services from a single doctor, and staff of seven nurses (three full-time and four, part-time) for approximately 300 detainees.

2. The physician's time was apportioned to provide physical examinations for new arrivals, with any unused time devoted to sick calls. (These levels of service meet or exceed the contract requirements)

3. The facility did not conduct regular daily sick call sessions or periodic follow-up sessions.

4. All off-site medical referrals were done by MD's orders. or at the discretion of RNs and/or ESMOR guards.

5. 70 percent of off-site referrals were not appropriate and should have been treated in the facility's clinic.

6. Sick call slips were stapled to the left flap of each medical chart, and no corresponding notes indicating the services rendered were seen in staff progress notes.

7. There were blank spaces in between progress notes in the majority of the charts.

8. All progress notes were written in non-soap format. ("soap" is a medical term of art referring to a generally accepted standard method of medical record keeping. It is a problem oriented way of medical charting - Subjective, Objective, Assessment, and Plan)

Dr Cheung concluded: "In the absence of existing evidence that sick call sessions were conducted daily and periodic follow up care was provided for any acute and chronic medical conditions by the qualified health care providers, it seemed obvious that all the problems had to be solved by sending them out to off-site medical facility."

Findings of May Assessment by Doctor Cheung:

1. A new physician came on board in March, and the physician work hours were increased to 20 hours per week.

2. The frequency of off-site referrals was substantially reduced compared to those referenced in the previous assessment.

3. There were overall marked improvements in medical record keeping and the recording of health assessments.

4. The contents of the charts reflected the quality of care to be optimal and compatible to that of community health care providers.

5. Although the format of medical record assembly was different from the INS-HSD's guidelines, all medical records were kept in a well-managed sequential order.

A copy of each medical assessment report was provided to ESMOR, and INS requested ESMOR to make appropriate changes to comply with the terms of the contract.

Findings of the INS Assessment Team:

As part of its overall review of ESMOR, the INS Assessment Team examined facility medical services. Based upon findings by PHS and Dr. Cheung, the Team concluded that individual medical evaluations of detainees who were seen during sick calls were timely and well done. However, as stated by Dr. Cheung, sick call was not conducted on a daily basis nor were there always necessary medical follow-ups as required under the terms of the contract.

The Team noted a conflict of findings between the PHS Assessment and that of Dr. Cheung. While the PHS Assessment Team characterized sick call as excellent, Dr. Cheung noted a failure of ESMOR to provide daily sick call and follow-up for detainees. In response to the Team's inquiry,

PHS said the decision of the medical authority (Dr. Cheung) would take precedence over the finding of the Medical Assessment Team with regard to the sufficiency of sick call.

Oversight of the medical operation was acceptable. When problems were suspected, Eastern Region PHS, in coordination with HQPHS, provided for a professional and thorough review which resulted in better health care service and ensured consistency within the parameters of the contract.

The Team found that many medically-related complaints were raised by the Office of Congressman Menendez, Councilman Orlando Edreira, and various attorneys. There was also a pattern by ESMOR of inappropriate use of off-site medical services. The following recommendation is based on these findings.

Recommendations:

a. PHS should take over the functions of all medical services provided on-site. Resources have been identified and such a move would be both cost effective and prudent given the consequences should a detainee not receive appropriate care while in Service custody.

H. Access to Counsel / EOIR / INS

The Assessment Team was advised by attorneys that access to their clients was severely hampered by the manner in which ESMOR enforced its visitation and telephone policies. The Assessment Team consulted with INS COTR Uzzle and ESMOR Facility Administrator Stovall. The Team also reviewed visitation logs and the detainee telephone system.

The Assessment Team found that there was a lack of consistency in ESMOR's administration of attorney visits to their clients. Further, there was little effective communication between attorneys and ESMOR and between attorneys and INS officers located at ESMOR. ESMOR changed the visitation policy without reasonable notification to counsel. Attorneys did not feel welcome to visit their clients. On two occasions, attorneys said, they were challenged without due cause by ESMOR guards who threatened them with expulsion from the facility. ESMOR could not produce a written policy reflecting the changes to attorney visitation. This led to confrontations between ESMOR and attorneys. The occurrence of confrontations was authenticated by attorney Joyce Phipps and ESMOR officials.

In some instances, attorneys were required to wait up to three hours to visit with clients. This was primarily due to a limited amount of attorney visitation space (although the space met contractual requirements) and a high number of consultations. The Team found ESMOR did not make a sufficient effort to reconcile the problem with attorneys. ESMOR overlooked or ignored

simple solutions to the problem such as asking attorneys to pre-schedule visits when possible, or providing information about when the facility was least busy.

Access was further hindered by the method of telephone service. The contract did not require that *pro bono* legal services be programmed into the system. Accordingly, detainees were hindered in obtaining counsel via direct calls because *pro bono* services do not accept collect calls. This also caused undue delays in their administrative hearings because Immigration Judges routinely granted continuances to aliens who wanted to but had not obtained representation. ESMOR accepted the recommendation of the Assessment Team without question, and these services were scheduled to be activated by June 21.

Recommendations:

a. ESMOR should post in a convenient place the visitation policy and any subsequent changes in policy.

b. Attorneys who regularly practice immigration law, along with free legal service groups, should be notified by mail of any changes in the visitation policy. INS should be able to provide lists of free legal service groups.

c. ESMOR should consider a method of scheduling a certain number of attorney visits. This could be done on a mutually acceptable schedule.

I. Physical Facility

Application of American Correctional Association (ACA) Standards:

The facility was designed by a recognized ACA certified architect to conform with the INS solicitation requirements and ACA physical plant standards as described in the ACA's *Third Edition, Adult Local Detention Facility Standards*.

Prompted by 27 escapes in the first four months of operation ESMOR modified all dormitories. They also invested a significant amount of money in a motion detection alarm system designed to detect intrusions into unauthorized areas. These two modifications helped reduce escapes to one in the following six months. That single escape was related to a failure of ESMOR personnel to follow policy by leaving a detainee outside the secure perimeter of the facility. This was a violation of INS' explicit written directive.

Review of the facility by the Assessment Team discovered the following items which either did not conform to the physical plant requirements of the contract, or to ACA standards referenced

as a guide in the contract for physical plant standards, or that may be subject to a legal sufficiency challenge:

1. At least two of the dormitories did not have sufficient access to natural light. In male dormitories, a minimal number of skylights were present but were inadequate. The remainder of the dormitories had windows at a height of approximately 25 feet, and there was no significant view to the outside other than the sky. Several of the female dormitories were located in the interior of the building and it is questionable whether or not a sufficient amount of indirect lighting was available.

2. Under the terms of the contract, there is a requirement for access to natural light in the segregation area. A requirement for three skylights over this area was noted in the contract and appeared on the "Best and Final Offer" that was originally reviewed by the Technical Review Team. There is no natural light in this area.

3. The outdoor recreation area is approximately 1,520 square feet, as required. It consists of a flat cement area with one basketball hoop and a volleyball net. However, only one activity can be conducted at a time due to the limited area available. The area is surrounded by walls approximately 30 feet high. There are multiple openings which allow in sunlight and fresh air. There is very little circulation of fresh air due to the depth and design of the recreation area. Because of the high walls and limited area, it is often difficult for more than 20 to 25 detainees to remain in the area without interfering with one another's activities. It is questionable whether this area would meet the legal definition of an outdoor recreation area.

4. No writing areas or chairs were provided in the segregation cells. The only furniture present was a bed, a toilet, and a wash basin.

5. In several of the dormitories, toilets were visible from some of the tables provided for detainee meals and recreation. Both as a matter of privacy and of good taste privacy panels should have been devised to correct this situation

6. Privacy walls in the female dormitory areas were approximately 36 inches high and afforded less privacy than walls in the men's dormitories. Female showers were visible from the corridor and could be viewed from areas outside the female area.

Other than as noted above, the facility was in good order and the physical plant was in good condition prior to the disturbance. Dormitories were designed in a manner which provides for a degree of privacy and comfort. The food service, medical, administrative, and lavatory sections were generally well designed and spacious allowing for easy travel and good general access. The facility was spread out in a manner which allows for excellent lines of sight throughout the walk-ways and

dormitory areas. There was no evidence of overcrowded conditions, as alleged in several media reports.

Recommendations:

a. ESMOR should be required to comply with the contract in adherence to ACA standards.

b. INS' procedures to accept a facility for operation need to be strengthened.

J. Contract Compliance

Note: Within this section each violation cited is followed immediately by the corrective actions taken and/ or recommendations.

On June 10, during the Assessment Team's review of the current contract, numerous instances of noncompliance were noted. The ACBADM Contracting Officer for this contract was requested to take immediate action on the following deficiencies. (Note: Other recommendations, noted elsewhere in this report, may also have contractual implications.)

1. Subsection 2. Personnel - Item C.(5); page 17 of the contract

Violation: The contractor failed to report all violations or attempted violations of the standard of conduct or any criminal activity to the COTR. It was found that ESMOR had withheld information from the INS COTR. The failure to provide timely and accurate information misled INS officials into believing that no violations were occurring. Reference the incident reports noted in the REPORTS and DETAINEE WELFARE sections of this report.

Recommendations:

a. Both the Facility Administrator and the INS COTR have been advised of this situation. It was recommended that the INS COTR institute daily requests about all incidents between detainees and guards and that the Facility Administrator report any incidents or allegations of misconduct to the INS COTR in a timely manner, as outlined under the terms of the contract.

2. Subsection 5. Physical Plant - Item D.3.(b)(3); page 31 of the contract

Violation: Detainees assigned to the administrative segregation unit did not have continuous access to natural light.

Recommendations:

a. The contract requires that a total of three skylights be installed in the area above the segregation unit. No skylights have been installed. The ACBADM Contracting Office needs to pursue the addition of the skylights in the segregation area.

3. Subsection 7. Sanitation and Hygienic Living Conditions - Item F; page 38 of the contract

Violation: Clean clothing must be provided twice weekly. Detainees complained of only one change of clothing per week. This was verified by the contractor. The contractor claims that detainees often damaged the clothing, making it difficult to meet this demand.

Action Taken: As required under the terms of the contract, ESMOR was notified by the ACBADM Contracting Office to take immediate corrective action.

4. Subsection 7: Sanitation and Hygienic Living Conditions - Item L; page 38 of the contract

Violation: The contractor must provide, at no cost to the detainees, appropriate footwear and undergarments, as needed. The contractor claimed that a limited supply of changeout clothing was available due to vandalism. Detainees were, on the average, only receiving one clean pair of underwear per week. In addition, it was discovered after the disturbance that female detainees had been issued male underwear which in most cases was several sizes too large.

Action Taken: As required under the terms of the contract ESMOR was notified by the ACBADM Contracting Office to take immediate corrective action.

5. Subsection 10. Security and Control - Item D.(5); page 47 of the contract

Violation: There must be a written record of each shift concerning the following: (1) the personnel on duty; (2) a detainee population chart; (3) shift activities (meals, recreation, religious services, etc.); (4) entry and exit of attorneys and other visitors; and (5) unusual occurrences. The current method of logging incidents is not sufficient for INS oversight. There is no general accounting of all activity by the control logbook. It is virtually impossible for the INS to identify potential trends and problems under ESMOR's current method of logging daily activities and incidents.

Recommendations:

a. The INS COTR needs to work with the Facility Administrator to ensure a single logbook which contains at least a minimum of the following information is kept within the control area and is available to the INS COTR or other reviewing INS Officer upon demand: (1) the personnel on duty; (2) detainee counts and security checks; (3) shift activities; and (4) any incidents, assaults, emergencies, or similar situations.

b. ESMOR must ensure a more appropriate method of maintaining logbooks which allow for Central Control to receive information at a single location regarding all significant incidents.

6. Subsection 11. Supervision of detainees - Item B; page 50 of the contract

Violation: Detainees are not permitted to supervise, control, or exercise any authority over other detainees. ESMOR has created a detainee committee to represent detainee grievances. Both the INS and ESMOR were attending these sessions. The Assessment Team review indicated that only a portion of detainee grievances were being heard and the detainees, for the most part, felt that the grievances in question were not always representative of the majority. Moreover, non-participating detainees expressed the belief that those detainees on the committee were "special" and "privileged", and were representing only "their own [interests]." This type of committee also places some detainees in a position of constructive authority and power which can be exerted over the rest of the population.

Recommendations:

a. The INS COTR will place a grievance box in each dormitory for the sole use of detainees. Detainees will be able to provide, directly to the INS, complaints, allegations, or other information which previously has not been provided by the contractor. The INS representative should no longer participate in the meetings between ESMOR and the detainees. It is the strong recommendation of the Assessment Team that this practice cease and emphasis be placed on instituting a two-way grievance system under which the INS would acknowledge receipt of complaints and indicate that they are being looked into. Such a system would facilitate the process of documenting the contractor's follow-up on complaints in a written form; provision being made for illiterate and/or non-English speaking detainees to present their complaints.

7. Subsection 11. Supervision of Detainees - Item E; page 50 of the contract

Violation: Assigned duty posts were abandoned or left unmanned by ESMOR employees in order to take breaks or accomplish other tasks. A shortage of personnel necessitated dorm guards leaving their posts to accommodate detainee phone calls outside the dormitory area. On the second day of the assessment, nine of the 17 guards assigned to work in the facility were observed simultaneously taking breaks outside. On a separate occasion the Acting Officer in Charge, Earline Boyer noted a female guard leaving her assigned post. This female guard was the only guard working what was supposed to be a two-guard post. When this guard left her post, unsecured female detainees were observed unsupervised in several areas. A review of staffing for the facility indicates personnel shortages were a daily occurrence. A preliminary review by RODDP at the request of the Assessment Team indicated that an average of six, and as many as eight, guards were being required to work double shifts each day.

Recommendations:

a. The COTR needs to monitor daily personnel assignments more closely.

b. The use of staff on double shifts is a hazardous practice and should be limited under the terms of the contract to those instances approved by the COTR for emergent circumstances..

c. Guards should not be allowed to work more than four hours beyond the normal eight-hour tour of duty.

d. When it becomes apparent that inadequate personnel are available to ensure appropriate coverage, the COTRs should request that RODDP consider a decrease in the daily population until ESMOR can provide evidence of compliance and a continued ability to provide personnel for each post.

e. The contract fails to define "tour of duty" or address the limits of the tours. A contract modification should be initiated to correct this deficiency.

8. Subsection 12. Detainee Rights, Rules, Discipline, and Privileges - Item E; page 52 of the contract

Allegations: There have been repeated claims of assaults on detainees by ESMOR guards, as well as numerous claims of harassment, and/or verbal abuse. The allegations have been made by several attorneys, and some ESMOR guards who requested not to be identified. Allegations ranged from continued verbal abuse by some of the ESMOR personnel, to accounts of physical abuse. The Assessment Team, interviewed numerous persons regarding these allegations. The Team had the

opportunity to judge the testimony presented and observe the demeanor of those persons involved, including attorneys, detainees, and guards, some of whom acted as confidential informants. The Team finds the overall testimony on these matters sufficient to warrant further investigation. If the allegations are true, this is in violation of the contract which requires the contractor to provide detainees protection from personal abuse, corporal punishment, personal injury, disease, property damage, and harassment. This also represents possible criminal violations.

Recommendations:

a. Increase INS oversight of the contract to 24 hours a day, seven days a week, to ensure proper performance and conduct of ESMOR staff.

b. Place grievance boxes in each dormitory for aliens to provide information and complaints directly to the COTR or his designee.

c. ESMOR must be required to provide timely reporting to the INS of any violation of detainee rights.

Action Taken: The facility as well as HQOIA were notified and an investigation is pending. The investigation by the Assessment Team uncovered the identities of seven guards who seemed to be principally responsible for the maltreatment of detainees. These allegations are being investigated as part of a Civil Rights Investigation pending with the FBI. Those guards who were identified have been precluded from working on this contract pending the outcome of the investigation. (Subsection 2, para H., d, 2.)

9. Subsection 14. Admission, Orientation, Release, and Property Found - Item H; page 53 of the contract

Violation: The terms of the contract require that any detainee be reimbursed immediately by the contractor for any personal property, monies and/or valuables for which the detainee has a receipt that the contractor is unable to return due to loss. theft. misplacement. etc. ESMOR attempted to place aliens on return flights without their funds and valuables. This became known to the INS COTR when it was discovered that the INS was being charged for detention of aliens who had removal orders and return tickets to their countries of origin. These aliens were being returned to the facility after they had refused to board their scheduled flights. When an inquiry was made to ESMOR, it was discovered that the aliens were refusing to board departing flights until they received their funds and valuables. ESMOR was placed on notice that the INS would not pay for any detention beyond the expected date of an alien's departure when failure to remove that alien was a direct result of loss of detainee funds, valuables, or property. Where it was found that property, valuables, or money was in fact missing, ESMOR reimbursed the detainees as required under the contract.

Recommendations:

a. ESMOR must provide tighter controls over the processing, storage and accounting of personal property. ESMOR needs to develop an auditable procedure for assuring the proper safeguards of all detainee property.

b. Any discrepancies in these records must be reconciled prior to their day of departure.

c. It may be possible for the contractor to adopt INS' own rigid control procedures for handling detainee funds and valuables.

10. Section F.8. Monetary Adjustments for Inadequate Performance - Item F.8.b.1; page 66 of the contract

Violation: The contract provides for monetary adjustments for the following violations: "Failure to man posts, post abandonments, omissions of required contract reliefs, exceeding restriction on tours of duty by more than four hours, posts which are unprotected after removals made pursuant to determination of unfitness according to Section C, Subsection 2, paragraph H.d, posts manned by guards who are sleeping or intoxicated."

On numerous occasions during the assessment visit and after the Assessment Team left, ESMOR guards were not at assigned posts or were observed leaving their posts to perform other functions. Also, as stated earlier, an average of six, and as many as eight posts each day, were staffed by personnel working a second shift. The manner in which supervisors assigned overtime created undue hardships on some of the guards. One female guard said that on at least two occasions, supervisors refused to relieve her. She was not allowed to leave the female unit until she "volunteered to stay" an additional shift. This coercion is also reported to have occurred with the male guards, until a sufficient number of "volunteers" were found.

Recommendations:

a. The INS needs to modify the contract to reflect that the official tour of duty is eight hours. The contract must spell out exactly when overtime and double shifting are permissible.

b. The COTR needs to immediately put the contractor on notice of any such violations.

c. Any adjustments taken on the contractor's monthly invoice should be supported by a detailed description of the violation and the amount being withheld.

While these non-compliances were noted during the assessment, there are additional underlying problems with the contract statement of work that need to be addressed.

The Statement of Work (SOW) was produced as a national standard for all detention contracts. This SOW was developed by INS Headquarters and provided to Eastern Region for inclusion in the solicitation package. The Regional Procurement and Detention offices expressed, to Headquarters, numerous concerns about the language and scope of the SOW, and they recommended specific changes. Headquarters was reluctant to alter any language since the SOW was to be a standard used at all INS detention locations.

The SOW developed was based on a performance type of specification rather than a more rigid design type of specification. The SOW describes the services that are minimally acceptable to meet the Government's requirements. In determining compliance issues, the contractor must only demonstrate that they (the contractor) meet the minimal levels. If the contractor is performing at these levels they should be meeting the Government's acceptable level of service. This type of specification works well for routine sorts of tasks. It is not structured to provide a level of Government involvement and direction necessary to assure the INS' interests and objectives are accomplished by the most effective means. The performance type of specification leaves too much discretion in the hands of the contractor. The contractor determines how best to carry out the required services. For example, the government does not mandate the number of security personnel required to staff a facility. Depending on the design of the facility layout, the contractors submit a staffing pattern that will meet the direct supervision and associated operational functions for that specific design.

The Assessment Team concluded that serious problems and deficiencies were present throughout the contract period. In general, ESMOR lacked essential consistency in its practices, and application of policies governing the operation of the facility. Furthermore, ESMOR's failure to provide vital information to the INS hindered the overall operation of the facility. The course of action pursued by ESMOR left INS in the unfortunate position of having to respond to issues and complaints of which, in many instances, INS had no prior knowledge. The Team found that ESMOR evidenced a continuing cycle of contract violations, failure to identify and correct problems, and general failure to follow sound management practices. Management of this facility by ESMOR was poor.

IV. Assessment of INS Operations Related to ESMOR

The Assessment Team reviewed INS' operations related to ESMOR in the following areas:

The Assessment Team initially set out to review the oversight of ESMOR by the Newark District. Areas of primary concern included oversight of the contractor, interaction between the INS COTR and ESMOR, and a general review of the manner in which some custody decisions were made by the District.

As a result of the disturbance on June 18, the review was expanded to also include an assessment of all components, including the management of "A" Files, removals, detainee liaison, EOIR issues, and community liaison.

The Eastern Region is continuing its review of files transferred from Newark/ESMOR to the Philadelphia District. These files relate to the aliens who were detained at ESMOR at the time of the disturbance, and were later transferred into the Philadelphia District. The report of findings from the Philadelphia file review will, upon its completion, become an addendum to this report.

The following information was assembled through site visits, interviews of INS and ESMOR personnel and with detainees, review of memoranda, and discussion of problems and issues with the Executive Office for Immigration Review (EOIR), ESMOR management, and the Newark District.

A. The Newark District

INS Staffing at the Facility:

At the time of the assessment the Newark Detention and Deportation Branch at the ESMOR facility was staffed by three Detention Enforcement Officers (DEO), three Deportation Officers, one Deportation Docket Clerk, two Deportation Assistants, one Supervisory Deportation Officer who also functioned as a COTR, and two Supervisory Detention and Deportation Officers (one the Officer in Charge [OIC] who also functioned as a COTR, the other a Supervisor of Detention Operations.) The facility has current vacancies for one Deportation Assistant and one Supervisory Detention and Deportation Officer. Of the staff described here, only the COTRs had oversight authority of the facility. Other staff performed solely INS duties related to actions outside the facility, i.e., making flight arrangements for departures, arranging for travel documents, or organizing detainee transfers.

Prior to the opening of the Elizabeth facility, the Newark District was allocated seven DEO positions, all of whom worked out of the district office. The ESMOR contract provided that contract

guards perform most alien transport between the facility and JFKIA and NEWIA. When the facility opened, Newark District was allocated an additional three DEO positions to perform airport-related alien transport duties not assigned under the contract to ESMOR guards, e.g., criminal exclusion cases destined for local jails. An INS office for DEOs was included in the facility's design.

The original staffing structure adopted by then District Director Tillman did not allow for close oversight of this multimillion dollar contract. The COTR duties at this location are far too extensive and time consuming to be combined with OIC duties associated with the management of a docket that eventually became 430 exclusion cases (additional exclusion cases from JFKIA and NEWIA are also detained in county jails in the Philadelphia District with venue remaining in Newark).

A history of extensive INS staffing changes at the facility, adversely affected the District's oversight of the facility. On or about March 13, Officer Rozos was detailed from his OIC/COTR position to that of Acting Assistant District Director for Investigations. Simultaneously, Supervisory Special Agent (SSA) Alan Freiss was reassigned from his duties as the Deputy Assistant District Director for Investigations to the position of Acting OIC at the ESMOR facility. Norman Uzzle, Supervisory Deportation Officer, was then assigned the duties of COTR for the facility in addition to his first line supervision duties. This staffing change more closely resembled original plans submitted by RODDP and HQDDP for INS management staffing of the facility.

This new focus on role of the COTR had the effect of promptly uncovering questionable conduct and practices by ESMOR that directly affected the safety and well-being of the detainees. ESMOR's response to Officer Uzzle's oversight and continuous flow of corrective action requests was to ask INS management to remove him from his position.

On April 24, Uzzle was relieved of his supervisory responsibility and directed to perform only COTR functions. On May 22, Earline Boyer, Supervisory Deportation Officer was reassigned from the District Office to the position of (Acting) OIC at ESMOR. SA Freiss was returned to his permanent duty post. The arrival of Officer Boyer provided for a second Contracting Officer on site to assist with monitoring of the facility and INS functions.

Twenty-four-hour-per-day oversight of a contract detention facility by an on-site COTR, or other accountable INS staff, is not the current INS policy nationally for these types of contracts. However, four days prior to the initial arrival of the Assessment Team, the Newark District began providing 20 hour coverage to monitor the facility interior. The results of this decision were excellent. Detainees' complaints dropped, and those who were interviewed by the Assessment Team said that instances of both verbal and physical abuse subsided. The presence of INS personnel acted as a deterrent to abuse and was welcomed by most of the detainees.

The Team concluded that three changes in INS leadership over the course of a ninety day period contributed to oversight problems. During these personnel changes, ESMOR distanced itself

from INS oversight and did not communicate information concerning the operation of the facility. Changes in the manner of oversight by different INS COTRs allowed ESMOR to make operational changes, in some cases contrary to the contract, which were detrimental to INS' interests.

Recommendations:

a. The facility staffing plan should be modified to meet current and future needs at this facility.

b. The current position of SDO should be converted to SDDO 13 with responsibility for both detention and deportation functions.

c. The position of SDDO (GS-12) should be converted to a Chief of Detention Operations (GS-12) and converted from 1801 series to 1802 series (No Deportation Officers are supervised by this position).

d. If it is the intention of the Newark District to continue using District DEOs at the ESMOR facility, it should be determined how much of their time is currently being devoted to user fee cases and removals and an appropriate number of positions converted from appropriated account expenses to user fee expenses.

e. Sufficient INS presence should be required in the facility on a 24 hour. seven-day-a-week basis.

f. If recommendation "e" is implemented by authorizing user fee DEOs. then those DEOs assigned to the District should be returned to those functions for which they were originally allotted.

Facility Oversight - The INS Contracting Officer's Technical Representative (COTR)

It was apparent to the Assessment Team that serious problems regarding the INS oversight of the ESMOR facility began prior to the temporary departure of Officer in Charge (OIC) and first COTR Michael Rozos to Newark District Investigations Branch, where he was assigned as Acting Assistant District Director for Investigations. However, further erosion of the operation was accelerated by the sudden departure of Officer Rozos and his replacement on March 13 with a less experienced COTR, Norman Uzzle.

Prior to April 24, when Officer Uzzle became full-time COTR, Mr. Willard Stovall, Facility Administrator told Officer Uzzle that changes in ESMOR procedures were typically agreed to verbally with little or no follow-up at the District or Regional levels. This type of practice, if permitted. would be disadvantageous to the INS because no written record would exist that

documented changes in policy, procedures. or practices in the facility. Officer Uzzle stated to the Team that he informed Mr. Stovall verbally and by memorandum that such a practice is unacceptable and would not be tolerated. The previous INS COTR, Michael Rozos was questioned concerning Mr. Stovall's assertion that changes were usually agreed to verbally. According to Officer Rozos, when he was COTR all changes were documented and maintained in accordance with the contract.

While the communication between INS and ESMOR remained unsatisfactory, Officer Uzzle was able to identify various problems with ESMOR's performance and relay this information to the Contracting Officer who then took the appropriate action. Specific problems noted were (1) a back-log of medical bills which had not been submitted to Region for payment; (2) unauthorized disclosure by the Facility Administrator concerning detainee medical issues he was neither qualified nor authorized to provide: (3) ESMOR guards providing legal advice to detainees; (4) documented funds and valuable discrepancies within the facility; (5) insufficient property safeguards; and (6) unanswered correspondence.

On May 22. Officer Boyer joined the INS ESMOR staff as Acting OIC and Second COTR.

The Assessment Team found that after the departure of Officer Rozos difficulties arising from ESMOR's failure to report problems to the COTRs were exacerbated by the COTRs' lack of specialized operational experience in a detention setting. Such experience is an important adjunct to the ability to effectively monitor a contract detention facility. Although both Officer Uzzle and Officer Boyer are exemplary Officers. and had attended and successfully completed the requisite training for their positions. they lacked the depth of experience in the detention field to enable them to independently identify many problems within the facility. There is no training mechanism available within INS other than on-the-job which could have provided them with the knowledge and understanding needed to monitor the contract in a fully comprehensive manner.

Deportation Docket / Removals / Statistics:

At the time of the disturbance. the Branch handled an average of 430 detained cases on their docket. This included an average of 300 detained cases at ESMOR and 130 cases detained at Lehigh County Jail in Pennsylvania

The Philadelphia District has been tasked by the Eastern Region with completing a comprehensive file review of detainees who were detained at ESMOR. On June 7 the Regional Director instructed the Newark District Director to complete and maintain statistics with regard to the detention and removal of aliens interdicted by JFKIA and NEWIA. An integral part of these statistics was the compilation and validation of the total number of admissions and removals for JFKIA and NEWIA cases.

The Team found evidence of a steady increase, during the last five months, in the removal rate for exclusion cases detained at ESMOR. This indicated that EOIR, INS' Trial Attorneys, and

the Deportation Division were beginning to work in a more coordinated manner as the facility's "growing pains" subsided. The Newark District provided to the Assessment Team documentation showing a total of 550 removals (exclusions or deports) during the period August 3, 1994 (when the facility opened) to June 18, 1995 (the date of the disturbance). In addition, 35 stowaway cases and 87 withdrawal cases were also completed (removed) from the ESMOR facility in the same period.

The scheduling of EOIR hearings remained problematic during the Assessment Team's visit. One day there were three Immigration Judges hearing cases in both courtrooms and a conference room. The following day, a total of only three hearings were scheduled.

Of great concern to the Team was the inability of the Service to remove an alien who desired to withdraw from proceedings and simply return home. Aliens under exclusion proceedings would often have to wait up to four weeks after a written request to withdraw from proceedings. This exceeded the national average by three weeks, and was of course reflected in a higher average length of stay.

Detention Decisions and Coordination:

The manner in which some District custody decisions were made, regarding where detainees would be located, caused concern to the Assessment Team. There were complaints that aliens still under proceedings, with local attorney representation, were being transferred to Lehigh County Jail, which is about one and one half hours away and located in the Philadelphia District. At the same time, detainees with no scheduled upcoming court dates and pending appeals were being held at ESMOR. There was a lack of consistency by the Newark Deportation Staff in deciding where detainees would be placed, this resulted in unnecessary movement of detainees.

Coordination of detainee movements between Newark and Philadelphia Districts was problematic. For example, the Assessment Team observed a detainee case terminated by the Immigration Judge solely because the detainee was late for court. The detainee had not been transported by INS to the facility until the date of the hearing. A Trial Attorney assigned to the facility told the Assessment Team that this was not the first time such a termination had occurred.

In addition to the review by the Assessment Team, the Eastern Regional Director has ordered a complete case file review of all detained cases assigned to ESMOR. The Assessment Team will be provided with the results of this project and an addendum to this report will be forwarded upon receipt and review.

Relations with Attorneys:

Complaints from some attorneys concerning their lack of access to their clients prior to court appearances went largely unanswered by both INS and ESMOR. In meetings with attorneys, the Assessment Team was presented with three unanswered letters to the District Office, as examples

of what attorneys indicated was the District's lack of response to their grievances. One letter was a request for INS intervention in alleged abuses by ESMOR personnel of the attorney's detained client.

Attorneys also expressed frustration and exasperation over the amount of time they consumed in attempts to merely locate their clients, and in dealing with a constant barrage of detainee complaints concerning their treatment while in ESMOR. Attorneys claimed there was little communication or assistance offered by INS personnel pertaining to their concerns.

The Assessment Team noted that the Newark District did meet with attorneys concerning the formation of a *pro bono* group. The group requested at that time to provide "know your rights presentations" to aliens detained at the ESMOR facility. This request was not worked out to the satisfaction of either the District or the pro bono group. The District complained that many of the attorneys were not always forthright in their concerns with the INS and that the attorneys did not respond to request from the INS to provide at least an outline of dialogue they wished to discuss. A second meeting was held at the district office on June 22 and was attended by various attorneys, American Immigration Lawyers Association (AILA), and District personnel in an attempt to establish a *pro* bono program within the district.

The district reported to the Team that in a majority of case inquiries by the various attorneys and *pro bono* groups representing aliens, the inquiries were requests focused on obtaining the release of the detainee rather than discussing the merits of the case.

Oversight by the Administrative Center and Regional Office (RODDP):

Oversight at the Regional level, by both ACBADM and RODDP, was made more difficult by a lack in efficacious communication with the District. Both Regional entities frequently found themselves responding to issues that came to their attention from the local news media and other outside sources. The constant challenge of responding to issues which should have come from ESMOR through the District, denied Region the ability to undertake unhurried unpublicized investigations, and hindered their ability to deal with each issue in a completely objective manner.

Recommendations:

a. All ESMOR's Post Orders, Policies, and Procedures should be further re-reviewed and approved by RODDP and HQDDP concurrently within 30 days of the release of this report.

b. COTRs should receive some practical training by working in an existing contract facility before being assigned to a new facility.

c. The District needs to work harder to improve attorney and community relations.

B. Juvenile Detention

INS' Juvenile Detention Policy:

Code of Federal Regulations, Title 8, section 242.24 contains INS' rules and regulations regarding the detention and release of juveniles. The regulations define a juvenile as an alien under the age of eighteen. INS' policy concerning the detention of juveniles is contained in the December 13, 1991 memorandum, entitled "National Policy Regarding Detention and Release of Unaccompanied Alien Minors." from then Commissioner Gene McNary to Regional Operations Liaison Officers, District Directors, And Chief Patrol Agents.

The national policy memorandum directs that all alien minors awaiting processing may be held by INS authorities in INS detention facilities having separate accommodations for juveniles or. if such accommodations are unavailable, in suitable state or county juvenile detention facilities. It further states that no alien minor may be held in a detention facility, whether an INS facility or otherwise, longer than 72 hours, unless the alien minor is charged or convicted of a criminal offense other than entry without inspection, is adjudicated a delinquent, has engaged in violent or disruptive behavior, is an escapee from another facility, is an unrepresented Salvadoran or cannot be moved for other extraordinary or compelling reasons.

The ESMOR Detainees:

As a result of the ESMOR disturbance on June 18, all of the aliens detained there were transferred the same day to facilities in the Philadelphia District. When the detainees arrived in the Philadelphia District, eight of them claimed to be juveniles. Detention and Deportation Branch personnel interviewed each of the eight, and reviewed the related Alien Files.

During interviews, two of the aliens quickly admitted to being over 18 years of age. Of the six remaining, Philadelphia Officers believed one was a juvenile and transferred him to a juvenile facility. He was later paroled to the custody of United States Citizen relatives.

The five aliens who continued to claim to be juveniles during the interview, were referred for forensic dentistry examinations to determine their ages. The forensic test revealed one individual's estimated age to be at least 21 years. The other four were found to be in the "vicinity of 18 years or less." These four were placed by the Philadelphia District at the Berks Youth Center in Leesport, Pennsylvania. On July 3 and 5, the Philadelphia District paroled three of the four to the custody of United States Citizen relatives. Efforts are ongoing to contact relatives for the remaining juvenile.

The individual whom the forensic test revealed to be an estimated age of at least 21 years, claimed to be a 14 year old United States citizen. He remains in custody at Berks County Youth Center, in a segregated area. Counsel for this alien will be requested to have the alien submit to wrist x-rays for corroboration of the dentist's opinion. As for his claim to U.S. citizenship, it was determined that he was an imposter, using the valid passport of a 14 year old citizen.

Newark's Response:

The Newark Districts' response to the allegation that juveniles had been held at ESMOR was that when an alien alleges that he is a minor the individual is immediately interviewed by a deportation officer to make a determination of age. However, most detainees at ESMOR have either presented fraudulent documents or no documents. If based on a visual inspection and interview the Deportation Officer believes that the detainee is a minor, arrangements are then made for placement in a youth facility. However, if after the interview the detainee has not satisfied the officer that he is a minor, the detainee is classified as an adult. Any case that is borderline is assessed in favor of the detainee and a determination of minority is made.

The Newark District stated that as these are exclusion cases, the"burden of proof" falls to the alien. If subsequent to the initial allegation of being a minor new information is submitted a complete review is done again. If a document is submitted by the alien to support his claim, and verification is needed, or the document appears counterfeit or altered, the document is sent to the INS Forensic Document Lab for analysis. The District also states that claims to an underage status are usually made only after the initial hearings or during the asylum process. If a parole request is denied, an alien often submits a claim to minority status, or claims to have a medical problem.

The Assessment Team's Findings:

The Newark District's method of determining custody of juveniles has several lapses. It mistakenly placed a burden of proof on the alien to prove he was a juvenile. Any alien suspected of being a juvenile must be separated from adults and then placed in a juvenile facility. However, because of the type of fraudulent documentation aliens detained at ESMOR arrive with, it is unclear when in the detention process an alien claimed to be a juvenile

Recommendations:

a. The Newark District should be directed to closely adhere to both the regulations in 8 CFR 242.24, and the 1991 policy memorandum regarding the detention of juveniles; placing particular emphasis on fact that the 72 hour limit for detention of alien minors commences when INS assumes custody of the juveniles.

C. Administrative Center Burlington - Office of Security re: Security Clearances

In March approximately 32 percent of the ESMOR staff, including the Facility Administrator Mr. Stovall, did not have the proper security clearances or waivers. ESMOR complained that the process of hiring personnel was difficult due to the long background investigation procedure required by the INS. The Assessment Team found ESMOR's complaint to lack credibility as a principal reason for under-staffing. The background investigation requirement is clearly stated in the terms of the contract, which specifies that the INS must be provided with properly completed clearance forms at least ten weeks before the expected entry on duty of any person. Furthermore, it was explained to ESMOR that a waiver may be obtained, for persons with no derogatory information in their background, usually within 30 days if the paperwork is properly completed and forwarded in a timely manner.

Of the 19 ESMOR security clearance packets pending approval in the INS Office of Security (ACBSEC) at the time of this investigation, 12 were improperly filled out. ACBSEC security personnel were originally detailed to the facility for one week when the contract was awarded to train ESMOR personnel, so as to avoid precisely this situation. The INS is not responsible for delays caused by incomplete paperwork submitted by ESMOR. ESMOR has now hired a personnel specialist to assist with review and completion of the paperwork required by the Office of Security. A personnel specialist would also be able to help ESMOR recruit persons better qualified for detention guard work.

Recommendations:

a. HQSEC should continue its review and assessment of the Administrative Center Burlington Office of Security and, if necessary, institute systemic improvements.

b. Remedial training or hands-on informational training should be provided to ESMOR to ensure there is no repetition of problems in properly utilizing the security clearance system.

D. Community Relations

As related to the Assessment Team by Congressman Menendez and *pro bono*-attorney representatives, effective community relations by the Newark District was sorely lacking. *Pro bono* organizations felt the District failed to appropriately respond to serious problems within the ESMOR facility. Congressman Menendez and attorneys said they did not feel the District Director was forthright in his response to their concerns and that their complaints were mostly unanswered or ignored. Further, they complained that they were unable to schedule routine tours of the facility.

The Assessment Team interviewed Warren Lewis, Newark District Director. Mr. Lewis provided open access to all operations and instructed his staff to provide all documentation requested, which they did. A review of the documentation showed the District was working diligently to correct the very sorts of complaints highlighted by the Congressman and attorneys. However, the Team found little evidence that the results of these efforts (or the fact that such efforts were being taken) were being transmitted to the Congressman and the attorneys. While the District was at times restricted in the type of response it could offer, based on directives from the Eastern Region concerning responses to the media and issues which could result in litigation, nevertheless, much more could have been done to directly reassure and respond to concerned community interests. Good work was being done but the community was not told of it. While the Assessment Team was there, the District did offer to arrange a tour of the facility for Congressman Menendez and other interested members of the community.

The Team found that the District, partly via reassignments of personnel within its own organization, was attempting to gain better control of the problems within ESMOR. The lack of approved appointments to key positions such as the Deputy District Director (DDD) and the loss of his Assistant District Director for Detention and Deportation (ADDD) left Newark with serious management deficiencies, although the deficits were in large part compensated for by the hard work of competent employees placed in acting positions.

Based on the information provided to the Assessment Team, we conclude that the District should have taken a more proactive approach to community relations. The District should have seen that serious problems were developing and responded in a more meaningful manner to concerned parties.

Recommendations:

a. The Newark District should develop a better working relationship with the Congressional delegation, attorneys, the local community, and others who have a vested interest in the manner for which INS conducts its business.

b. In support of recommendation "a" the District should form a Community Working Group, composed of individuals from INS, ESMOR, and members of the entities noted in "a". This group could meet monthly, or as needed, to ensure community participation in issues of community interest.

c. The District should work with ESMOR to provide easier (but controlled) access to the facility for concerned parties in the community.

E. Eastern Region Detention and Deportation (RODDP) and Administrative Center Burlington Administration (ACBADM)

Over the course of the contract, ACBADM has maintained oversight of the contract and intervened when necessary to ensure contract compliance. ACBADM had almost daily contact with the COTRs and ESMOR concerning problems brought to their attention by the Newark District, RODDP, the news media, and various other sources. Regional personnel were committed to responding to complaints which increased weekly over the course of the contract.

ESMOR has generally complied with corrective action demands. These demands have included such items as: (1) corrective action to prevent an almost continuous chain of 27 escapes such as were experienced during the first four months of operation; (2) cessation of the use of leg restraints during visitation; and (3) ESMOR's policy of charging detainees for lost items such as spoons, clothing, cups, and other items. While ESMOR was generally responsive in making required corrective actions. INS could not always identify issues needing corrective action. because ESMOR kept information from INS.

In March 1995 RODDP reduced the facility's population while it attempted to resolve staffing. security, off-site medical referral concerns. and other issues brought to the attention of ESMOR by Regional Contracting and Regional Detention and Deportation personnel. When it became apparent that additional INS oversight was needed at the facility, a second COTR was added to the contract. Officer Boyer was assigned to this COTR position. Throughout this period. there was no indication that ESMOR voluntarily provided any information to INS relating to incidents. But they failed to inform the COTR of many problems which the Assessment Team later determined had been occurring with gross regularity. It was apparent to the Assessment Team that ESMOR management was not in full control of its mid-level supervisors or guards at the time of the assessment.

Recommendations:

a. INS must ensure that ESMOR is providing accurate verifiable information. Currently daily communication is made only to discuss an existing problem An open line of communication needs to be maintained on a daily basis instead of weekly, whether or not a current problem exists. A full-time INS presence is needed at this site.

F. The Hearing Process

The Assessment Team reviewed documents and statistics provided by INS and the Executive Office for Immigration Review (EOIR) concerning detainee hearings and length of stay in detention. The team also participated in interviews with INS and ESMOR personnel. EOIR interviewed its

personnel, including some Immigration Judges, and met with INS officials and members of the Assessment Team to present their views. The Assessment Team has attempted to develop, through cooperative efforts with EOIR, a substantially complete picture of the hearing process at the ESMOR facility and the causes of delay in that process. Nevertheless, this report does not address some areas in which disagreement between the Assessment Team and EOIR could not be resolved in a short time-frame. For this reason, and because the INS and EOIR are independent agencies, the Assessment Team suggests and recommends that a cooperative review should be conducted to examine the INS-EOIR relationship, to identify and resolve problem areas.

Background:

An inefficient administrative hearing process at the ESMOR facility resulted in lengthy processing times and extended periods of detention. As a result, detention costs were high, the removal rate was lower than expected, and INS enforcement goals were compromised. All three operational components, INS, ESMOR, and EOIR contributed to this problem. The INS' contract with ESMOR failed to include necessary provisions to ensure an efficient hearing process. These contract defects could have been avoided if the INS had involved EOIR more closely in drafting and reviewing the contract provisions, to include those pertinent to the hearing process. At the same time, EOIR did not fully staff the ESMOR facility with judges and clerks, and the INS Office of the General Counsel was unable to fully staff the facility with trial attorneys and clerks for the same reason. This may have been due in part to a late decision by INS to hear all New York user-fee cases, including persons detained in other locations, at the ESMOR facility.

As a result of these planning deficiencies, the local INS, EOIR, and ESMOR operations personnel were placed in a difficult position from the inception of facility operations. Under the strain of these pressures, local personnel became involved in disputes over operational matters and failed, in some respects, to maintain a professional working relationship. ESMOR failed to ensure that detainees were presented in court in a timely and efficient manner. ESMOR also failed, for a substantial period of time, to fully cooperate with the INS and EOIR in establishing a hearing schedule that would meet the needs of all involved parties. This is in direct contrast to ESMOR operations in Seattle, Washington, where close and productive working relationships have been formed. The INS COTR was not fully effective in remedying these problems with ESMOR or in mediating the local disputes among the various operational components.

After the Newark District Director presented these issues to the INS Regional Office, INS, EOIR, and ESMOR management made concerted efforts to remedy the situation. These efforts led to steady improvements in the hearing process, but progress was slow due to the size of the obstacles that had to be overcome. Meanwhile, the administrative hearing process was not proceeding in a timely manner and many detainees were experiencing delays in their cases. At the time of the disturbance, the operational difficulties had markedly improved due to constant efforts and hard work to remedy the situation. Further improvements were planned. Nevertheless, many detainees who had experienced delays remained in the facility.

Statistics On Removals:

The average length of detention at ESMOR is estimated at 110 days (including newly arrived detainees and detainees with cases pending). The total of 1153 cases filed with EOIR evaluated against the approximately 88,000 mandays charged by ESMOR, indicates a per detainee average length of stay in the facility of 78 to 80 days. This number, however, does not account for the fact that many aliens were housed at different times in two separate locations. The actual total length of detention is probably closer to between 100 and 115 days or more based upon the actual number of cases processed. From the time ESMOR opened in August 1994 through mid-June 1995, there was an average docket of 256 active cases. EOIR completed 892 of 1153 cases received through the Immigration Judge level. Of the 892 cases completed, 809 received final orders (including release and removal orders), and 83 are pending appeal. Of the 809 final orders, a total of 663 orders for removal were issued. Of the 663 orders for removal, Newark records indicate 550 were removed under an orders of exclusion. Compared with other INS facilities housing excludable aliens, this is a low number of removals even for a new facility.

Statistics On Delays in the Hearing Process:

Statistics provided by EOIR and Newark District records demonstrate delays in the hearing process at ESMOR. On average, detainees were scheduled for their first hearing before an Immigration Judge (referred to as a "master calendar" hearing) two weeks after the INS filed the charging document with the immigration court. EOIR generally aims to schedule first hearings for exclusion cases within three days. The nationwide average is eight days for all detained cases and 14 days for detained exclusion cases. In over a third of the cases, it took more than three weeks for the detainee to receive an initial hearing. Over the last three months of facility operation, this average rose. In April the average time to a first master calendar hearing was 18 days, in May 24 days, and in June initial hearings were being scheduled an average of 28 days out. This increase was due in part to the increase in case receipts for April (120), May (108), and June (92 in the first two weeks) compared to January (41), February (36) and March (48). This increase would have soon stabilized, with an accompanying sharp decline in the waiting period to an initial hearing.

The statistics also indicate that the initial hearings were often set at widely varying time intervals. For example: (1) of eight cases received by EOIR on October 3, 1994, four were scheduled to appear within three days, three were scheduled 16-17 days out, and one was scheduled 23 days out; (2) of 17 cases received by EOIR on April 24, 1995, eight were set for the next day, five were set two weeks out, and four were set over three weeks out; and (3) of seven cases received on May 9, 1995, two were set for the next day, two were set 10 days out, two were set 24 days out, and one was set 30 days out. The variances may have been caused in part by requests from attorneys to reschedule the initial hearing, upward adjustments in master calendar time to account for high numbers of case receipts in a short time period, and/or expedited hearings for some detainees who notified ESMOR or the INS of their decision not to contest exclusion.

For those cases in which a detainee applied for relief from deportation (the relief sought was almost exclusively asylum), EOIR statistics indicate that the average length of time from the initial hearing to an Immigration Judge decision was about four and one half months (134 days). For the period from February 1, to June 22 the average was over five months (160 days). At the time of the disturbance (June 18), this situation appeared to be improving significantly. The number of pending asylum applications had dropped from a high of 249 to 72. In addition, of the 47 cases which were pending more than 90 days, 37 were scheduled for individual hearings within three weeks.

As a result, a detainee who applied for asylum could expect, on average, to be detained for about five months before receiving a decision from an Immigration Judge. Close to a third of the cases in which an asylum application was submitted (including those cases where the application was later withdrawn) took six months (180 days) or more. EOIR's goal is to complete these cases within three months. The nationwide average for exclusion cases where an application for relief is filed is four months. EOIR statistics indicate that 394 detainees filed asylum applications, and that 72 of these were withdrawn before a decision was reached by the Immigration Judge.

Detainees who appealed an Immigration Judge's decision to the Board of Immigration Appeals (BIA) could expect an average of three additional months of detention. EOIR statistics indicate that 151 appeals were filed.

Detainees who did not apply for relief from deportation could expect to be detained, on average, for 20 days before receiving an exclusion order from an Immigration Judge (this average may be somewhat misleading, as it includes cases where the detainee indicated the intention to file an asylum application, but later decided not to file). The nationwide average for all detained cases is 13 days.

Causes of Delay in the Hearing Process:

INS shortfalls

The INS contributed to delays in the hearing process by failing to include sufficient provisions in the contract with ESMOR to: (1) ensure that ESMOR would present detainees on time for hearings, (2) ensure that the hearing schedule specified in the contract provided sufficient time periods for immigration hearings; and (3) ensure sufficient flexibility on the part of ESMOR to accommodate the continuation of individual hearings past the normal courtroom schedule where necessary to efficiently conclude a hearing. Sufficient input was not obtained from EOIR concerning these contract provisions, affecting the efficiency of the hearing process. The contract also failed to ensure that the court holding room was constructed with a bathroom. The lack of a bathroom in this room made it difficult for ESMOR to use this room effectively.

Even though the contract was deficient in some respects, the INS COTR appears to have been unable to resolve some of these problems with ESMOR in a timely manner, and was not fully

effective in mediating disputes with ESMOR concerning matters of the court. Local ESMOR, INS, and EOIR officials were unable to achieve a cooperative working relationship which was necessary to operate with the greatest proficiency. The Team concluded that local INS and ESMOR officials attempted to meet EOIR's operational needs by working within the existing contract, without sufficient efforts to achieve a long-term solution by modifying the contract.

The INS district also contributed to delays in the hearing process through inconsistent decision-making regarding location of custody. While the general approach was to use Pennsylvania jails to house detainees with cases on appeal, for a period of time ESMOR detainees were transferred to Pennsylvania jails before their Immigration Judge hearings were completed. In addition, the Assessment Team learned that in some cases detainees at Pennsylvania locations were not presented at ESMOR for their scheduled hearings. This failure resulted in approximately 21 continuances according to EOIR records.

The Assessment Team discovered complaints by *pro bono* and other attorneys regarding the manner in which INS detained and transferred aliens between local Pennsylvania jails and the ESMOR detention facility. The INS maintains the right to detain excludable aliens at the location of its choosing. However, the Assessment Team found that in many cases the district did not notify counsel of record when their client was transferred. This practice contributed to delays in the hearing process by causing hearings to be continued.

The INS did not keep current the legal services list located inside the facility dormitories. This list reflects local organizations or attorneys who are willing to provide free or low cost legal advice and representation to detainees. Additionally, the contract did not provide that detainees should be able to place telephone calls to the listed organizations and attorneys free of charge (these numbers can be programmed into the private telephone system used at ESMOR). Since *pro bono* organizations generally do not accept collect calls, especially from detainees whom they do not represent, indigent detainees often had difficulty contacting these organizations. This situation provided grounds for Immigration Judges to grant longer continuances for a detainee to obtain counsel.

During initial visits by attorneys, ESMOR employees, acting on INS' attorney visitation guidelines (which are currently under review by INS) required attorneys to file Form G-28 (Notice of Appearance as Attorney or Representative) with the INS, before granting access to a detainee. Some attorneys thought it improper to file this document if they had not yet established an attorney-client relationship. As a result, several attorneys were denied access to detainees.

Several attorneys advised the Assessment Team of efforts to establish a *pro bono* program at the ESMOR facility, similar to that at INS' facility in Florence, Arizona, which would provide detainees with some measure of legal advice soon after they were detained. All detainees would be screened by a legal service provider, and initial advice would be provided to each detainee concerning the merits of the case and whether or not the detainee was likely to qualify for relief or

benefits under the law. The Assessment Team believes that such a program would contribute to an efficient hearing process, especially at facilities such as ESMOR which process exclusion cases. The program would enable detainees to make quick and informed decisions whether to apply for relief or to admit excludability. The INS has been working on this program at the Headquarters, Regional, and District levels, but progress has been slow.

The INS Office of the General Counsel was unable to fully staff the ESMOR facility with trial attorneys and clerks due to lack of resources. The trial attorneys assigned worked overtime to keep up with the caseload, but sometimes did not have enough time to fully prepare for court.

Contractor problems

Delays in the hearing process were caused by a failure on the part of ESMOR to efficiently move detainees to and from immigration court, and to present them for hearings in a timely manner. This was further aggravated by the fact that local representatives from ESMOR, the INS, and EOIR were unable to work together to resolve operating difficulties at the scheduled weekly meetings. This finding is supported by comments, memoranda, and letters provided to the Team from INS, ESMOR, EOIR, and independent attorneys who complained about the manner in which ESMOR, the INS and EOIR conducted court business. EOIR has indicated that throughout the term of the operation of the facility, ESMOR was consistently late by 10-15 minutes in presenting aliens for master calendar hearings. In addition, ESMOR's mandatory policy to lock down detainees at 11:00 a.m. and 4:00 p.m. removed any flexibility the court may have wished to exercise in hearing additional cases and continuing cases past the cutoff times where necessary.

ESMOR was also unable to move detainees in such a manner as to avoid delays in master calendar hearings. The main reason was an ESMOR policy, approved by INS, to allow into the courtroom only a small number of detainees at one time. This policy was followed during master calendar hearings, notwithstanding a desire of the Immigration Judge to hear cases in larger (more efficient) groups. Additionally, ESMOR's practice of terminating detainee movement at 11:00 a.m. and 4:00 p.m. to conduct head-counts or provide other services (some of which were required under the contract), sometimes resulted in continuances being granted or delays in the hearing process.

In late 1994, in a meeting with the EOIR Court Administrator, OIC Michael Rozos told the Administrator that he should provide in writing to INS any requests for modifications needed to accommodate the hearing process. Officer Rozos advised the Administrator that he would pursue any requested changes with the ACBADM Contracting Officer for the appropriate contract modification. No written requests were ever received by INS.

EOIR staffing:

Hearings were held at ESMOR for detainees who arrived at JFKIA and NEWIA, but who were located in other facilities. As a result, the Immigration Judges at ESMOR were handling exclusion hearings for approximately 300-350 detainees once the ESMOR facility reached capacity. The average active caseload was 256 cases. By usual standards, this would indicate the need for two permanent Immigration Judges to be stationed on-site. In coordination with EOIR, the facility was built to accommodate two permanent Immigration Judges and their staffs.

EOIR did not assign a permanent Immigration Judge to the facility until February 1995 (seven months after the facility opened). Initially, EOIR was only able to provide the equivalent of one Immigration Judge at ESMOR by scheduling visiting judges stationed in Newark, New York, and other locations throughout the country. These judges had an existing caseload, and were rotated through ESMOR for short time intervals. In late 1994, EOIR increased the schedule of visiting judges. After February, EOIR provided the equivalent of two permanent judges at the facility by supplementing the permanent judge with visiting judges.

EOIR also initially assigned one on-site administrative clerk to the facility. Staffing at the ESMOR facility, with its caseload of 256 active cases for 300-350 detainees, if it were to be comparable to EOIR staffing at other INS facilities where exclusion cases are conducted, should have included four full-time EOIR clerks. Currently, due to staffing shortages, EOIR attempts to staff at a ratio of two clerks to each Immigration Judge. In December 1994, EOIR added two additional clerks to the facility. A third was assigned in March. The clerk who was initially assigned to the facility was hired from the United States Attorney's Office and had no prior experience running immigration proceedings. He was assisted by a court administrator stationed in Newark and by another clerk in Newark.

The EOIR administrator who was handling the existing Newark District docket was given the additional responsibility of overseeing the ESMOR hearing process from his location in Newark. A permanent Court Administrator was stationed on-site in the latter part of May.

Some cases were continued for significant periods of time. In some instances, it appears that some Immigration Judges would grant an adjournment or continuance of one month to allow a detainee to obtain counsel. In some cases, the Assessment Team found continuances in excess of three months from one hearing date to the next (for reasons which are not yet clear). The Team has provided EOIR with ten examples for further investigation and response.

Efforts to Remedy Delays in the Hearing Process:

The INS Newark District informed EOIR that there were numerous problems with the hearing process at the facility, including the lack of sufficient EOIR resources. In October 1994, the District Director wrote a detailed memorandum to the Regional Director, entitled "ESMOR's First

Sixty Days" outlining these issues. This memorandum was passed on to INS Headquarters and to EOIR. EOIR Director Anthony Moscato, along with Newark District Director Warren Lewis were instrumental in organizing weekly meetings between INS and EOIR to resolve differences between the agencies at ESMOR. Weekly meetings with EOIR were set up at the District level and shortly thereafter, Regional Operations, Regional Counsel, General Counsel, and Headquarters EOIR became involved in this process. Through the hard work of all involved, progress was made toward resolving operational issues at ESMOR.

Two documents in particular demonstrate the work that was put into improving the situation: (1) a December 12, 1994 memorandum from Chief Immigration Judge Michael J. Creppy to EOIR Director Anthony C. Moscato; and (2) a January 3, 1995 memorandum from Thomas L. Pullen, Assistant Chief Immigration Judge, and Jack Penca. INS Regional Counsel, to Chief Judge Creppy, Director Moscato, Carol D. Chasse, Regional Director, and T. Alex Aleinikoff, General Counsel. Both memoranda, which were generated at the request of the Director for EOIR, Anthony Moscato, describe progress made, and contained detailed solutions to the operational problems at the ESMOR facility. The efforts led to steady improvements in the hearing process, but progress was slow due to the obstacles which had to be overcome. EOIR placed a permanent Immigration Judge at the facility in February. At the time of disturbance, EOIR was planning to add a second permanent judge in September 1995.

Planning the ESMOR Facility:

EOIR was informed of the proposed facility early in its planning stages and was involved in planning the physical layout of the space which its personnel would occupy. It is not known exactly when this involvement began, but documentation indicates that EOIR approved of proposed floor plans as early as June 1992. In coordination with EOIR, the facility was designed with courtrooms and space for two permanent Immigration Judges and staff. While the facility was being built, and for a short time after ESMOR opened, the INS responded to numerous requests from EOIR to conform the EOIR section of the facility to agreed-upon specifications. It does not appear that the INS involved EOIR in reviewing the provisions of the contract relating to the hearing process at the facility.

During the planning of the facility, the INS tried to convince EOIR to commit permanent judges and personnel to the facility for the sake of efficiency and in anticipation that the facility would quickly reach its rated capacity. Headquarters Detention and Deportation Program (HQDDP) wrote to EOIR on this subject as early as August 20, 1993. EOIR indicated in a September 1993 memorandum that it would not initially assign a permanent judge to the facility, but rather planned to initially cover ESMOR with visiting judges. At that time, EOIR did commit to moving a position from New York to Newark after the planned retirement of an Immigration Judge (The Immigration Judge retired in December, 1994 and the position was filled in Newark by February 1995). The INS Eastern Regional Office sent a detailed analysis to HQDDP explaining the shortfalls of this plan to cover the facility with visiting judges. Subsequently, HQDDP again wrote EOIR in January 1994

expressing the need for EOIR to assign permanent personnel to the facility. In February 1994 EOIR again sent a negative response to HQDDP. At about the same time, EOIR agreed to hear all New York user fee cases at ESMOR, which meant that all Wackenhut (New York) cases arriving after the opening of the ESMOR facility would be added to the docket of 300 anticipated cases at ESMOR.

The INS and EOIR make independent budget requests to the Justice Department Management Division (JDMD). The JDMD generally requires "coordination" between intradepartmental agencies, but leaves open specifically what kind of coordination is required on a given project such as the ESMOR facility. The Department's Detention Coordination meetings are intended to fill this purpose.

Perhaps a more formal "coordination" process would be worth exploring. One option might be for the INS Detention and Deportation Program to develop, in conjunction with EOIR, a comprehensive written funding plan early in the planning process. This would include the projected needs of all Governmental components including EOIR, HQDDP, and INS Office of the General Counsel (which provides trial attorneys for immigration hearings). Where EOIR and the INS disagreed on required funding, the written plan could identify the differences and the competing rationales. In this way the plan could provide a more formal basis on which to resolve funding conflicts early in the planning stages for new detention space. Once the plan is finalized (with Department input as necessary), it could be attached to each agency's independent budget request to serve as a record of how approved funds should be utilized if approved. Something similar to this may have been followed recently in requesting budget approval for the Institutional Hearing Program.

The ESMOR experience illustrates that failed coordination between INS and EOIR results in waste and jeopardizes the humane treatment of asylum seekers and others awaiting a decision from an Immigration Judge. Detention becomes prolonged in a facility designed primarily for short-term stays.

The Assessment Team has made the following general findings based upon the information provided by EOIR, INS, ESMOR, and other involved parties:

1. The length of detention and delays were caused by the lack of cooperation of all three parties at the local level.

2. The process by which contract requirements were made concerning EOIR functions did not adequately involve EOIR in the planning and implementation the operation of the court.

3. The INS must make efforts to include EOIR in all planning aspects that directly affect it.

4. Additional positions should have been added to improve court-related security and allow for larger hearings if needed.

5. Local personnel from ESMOR, INS, and EOIR continued to have adversarial relationships that were not in the best interest of the aliens or the three parties. This prompted action to be taken at higher levels. However, oversight could not completely resolve or overcome severe personality conflicts, in particular those developed between the EOIR court administrator and ESMOR's Facility Administrator. The INS COTR could have been more active in his efforts to mediate in this dispute.

Recommendations:

a. A cooperative review between EOIR and INS should be conducted to examine the INS-EOIR relationship, to identify and resolve problem areas.

b. In the future, INS should involve EOIR at an early stage of facility planning in all aspects related to the hearing process at the facility. This would ensure the interests of both agencies were better represented.

c. The current contract with ESMOR should be modified to implement changes needed to support the hearing process.

d. The District should ensure that counsel for detainees are apprised of the transfer of their clients. When possible, they should be notified prior to the transfer.

e. The District should ensure that detainees have easy access to a current list of *pro bono* legal representatives.

f. Detainees should have the opportunity to make free telephone calls to *pro bono* legal representatives.

g. INS Headquarters should publish its policy on whether or not there is a need for attorneys to file Form G-28 (Notice of Appearance of Attorney or Representative) in order to visit non-client detainees in custody.

h. Increased effort should be made to establish a pro bono program at ESMOR, similar to that at the INS facility in Florence, Arizona.

i. The contract should be modified to require ESMOR to establish practices that better accommodate the defined needs of the Immigration Court.

j. INS should work with EOIR to better clarify, at an early stage, funding issues related to new detention facilities.

G. Newark Asylum Pre-screening Officer (APSO) Program

When ESMOR opened in August of 1994, there was no program in place to conduct APSO interviews for any detained asylum applicants due to a lack of resources in the Newark District Counsel's office. After the District Counsel began receiving requests for APSO interviews (requests were generally made by the detainee's counsel), Eastern Regional Counsel made arrangements to detail a trial attorney from Swanton, Vermont to conduct the requested interviews. Interviews were conducted during details between September 1994 and January 1995. The details were spaced approximately six weeks apart. These interviews were completed successfully, but a few problems were experienced. Because of the spacing of the details, a small number of detainees had to wait several weeks to receive their interviews. In addition, some problems occurred in the timely transport of detainees being held in Pennsylvania to ESMOR for the scheduled APSO. In a few cases, the APSO interviewer and the alien's attorney waited several hours past the interview time for the detainee to arrive. In April 1995, the Newark District Counsel obtained additional personnel, and a Newark trial attorney was designated to conduct APSO interviews upon request at the ESMOR facility.

At the time of the disturbance on June 18, the INS had conducted 30 APSO interviews and recommendations. All detainees who had requested an APSO interview received one. The APSO recommended parole (release) to the District Director in seven cases (23%), and in the remaining 23 cases the APSO recommended continued detention. INS records could confirm only one parole decision by the District Director in response to the APSO recommendations. The rate of EOIR asylum grants for the ESMOR docket is currently 14% (35 grants out of 250 completed asylum cases), according to EOIR statistics.

Of the seven cases in which the APSO recommended parole, one was granted asylum by the Immigration Judge, two were denied asylum, and the remaining four cases are pending a hearing before an Immigration Judge. This is a grant rate of approximately 33% (1 of 3 completed cases). In the remaining twenty-three cases, twelve were denied asylum, four were granted asylum, three were granted withholding of deportation, two cases are pending, and in two cases EOIR records suggest that the alien has not yet applied for asylum. This is a grant rate of approximately 37% (7 of 19 completed cases).

The APSO program is designed to help the INS make wise use of detention space while addressing humanitarian concerns raised by extended detention of credible asylum-seekers. Given the long processing times at ESMOR, a stronger APSO program would have served these goals. The 35 cases in which the Immigration Judge granted asylum represent potential beneficiaries of a better program. A stronger APSO program will require an additional dedication of resources.

The manner in which the APSO program is currently executed should be reviewed before further resources are invested. The statistics cited above raise questions about the relation of the District Director's parole decisions to the recommendations of the APSO. At the same time, the statistics raise questions regarding how well the APSO recommendations corresponded to the ultimate asylum decision by the Immigration Judge, especially since the standard applied by the APSO is more generous than that applied by the Immigration Judge.

Recommendations:

a. More resources should be devoted to the APSO program.

b. The Newark APSO program should initiate a program to ensure that there is greater outreach to the *pro bono* community.

c. The Newark APSO program should develop a procedure whereby they furnish affected aliens with timely information related to their case, i.e., the length of time it takes to process a case.

d. The manner in which the APSO program is currently executed should be evaluated to ensure the goals of the program are achieved.

V: Review of the ESMOR Disturbance

The Assessment Team reviewed the ESMOR disturbance in the following areas:

On June 18 at 1:10 a.m. a disturbance erupted at the ESMOR Detention Facility in Elizabeth, New Jersey. At the time of the disturbance there were 14 ESMOR personnel and one INS Officer on site. A total of 315 detainees were housed at ESMOR at the time of the disturbance.

The disturbance was under control by 6:30 a.m. after a tactical entry was performed by law enforcement officers. Newark District (INS) informed the Team that approximately 140 to 150 law enforcement officers, ten ambulances and various medical personnel were on site as a result of the disturbance.

On June 19, the role of the Assessment Team was expanded to include a review of the disturbance. The assessment was to include a determination of the possible causes of the disturbance and review ESMOR's response and handling of the emergency.

The following material was developed from information gathered through site visits, interviews with ESMOR personnel, interviews with INS personnel, and off-site detainee interviews.

A. Known and/or Probable Causes of the Disturbance

The following list of causes identifies the major factors contributing to the disturbance.

1. **Treatment by ESMOR personnel:** There was a continuing lack of respect shown by ESMOR security personnel towards the detainees. Guards often harassed detainees and on occasion would challenge the detainees as a means of humiliating them in front of peers. Harassment by guards was mainly psychological, or verbal.

2. **Escape plan:** The Assessment Team found that the initial cause for the disturbance was to provide a distraction for detainees who had developed an escape plan. This group was able to incite the detainee population by using conditions of confinement issues and detainee treatment issues as a catalyst.

3. **Frustration over time of detention:** This factor has been cited by INS and ESMOR personnel. The detainees did not appear to understand that the complexities of their exclusion cases, and the selections they made to avail themselves of all possible legal processes, were major reasons for the lengthy time of detention. The detainees were unwilling to accept the fact that their continued detention resulted from their attempted illegal entry into the United States.

4. **Lack of communication:** Generally, the detainees only daily contact was with ESMOR personnel. Detainees felt they had no safe channel for communication with INS personnel at the facility. For detainees, the normal path for communication to INS lay through ESMOR guards, the same people about whom detainees wished to register a complaint.

5. **Frustration with the legal system:** As related by Officer Michael Rozos and other INS managers on-site, the detainees were frustrated with the number of continuances given by Immigration Judges, and what they perceived as inconsistency in EOIR calendars. Some of the detainees also complained of selective representation tactics of *pro bono* attorneys. They claimed that *pro bono* attorneys prefer certain types of cases and would not represent many detainees for reasons that the detainees felt were

discriminatory. Additionally some detainees complained of deceptive practices by some private attorneys representing detainees.

B. On - Site Response to the Disturbance

The Assessment Team was provided with memoranda and notes concerning how ESMOR personnel responded to the disturbance. Additionally the Team interviewed numerous detainees and persons who had been on-site at the time of the disturbance. The Assessment Team has requested all training lesson-plans and curriculum materials in order to further evaluate ESMOR's response to the disturbance. The following information is based on material provided to the Assessment Team by ESMOR management, Officer Uzzle INS COTR, interviews of 11 INS detainees (including a confidential informant), and four ESMOR guards.

The disturbance began in housing unit "F" with an assault on an ESMOR guard. The assault was carried out by five detainees in an organized manner. ESMOR personnel responded to assist and the detainees retreated. A second assault broke out in housing unit "H" with the target of the assault being the housing unit guard. The duty supervisor, realizing he may be facing a serious problem, ordered all housing unit guards into the hallway. This was an appropriate order since two separate assaults had occurred within a short period of time and in an organized manner. At 1:10 a.m., detainees began assaulting the housing unit perimeters in an attempt to break out and into the hallway. A single security window was cracked and one guard suffered a cut lip from flying glass. The ESMOR supervisor ordered all guards to vacate the facility contrary to the Emergency Plan.

At 1:15, Officer Uzzle stated, he heard a commotion in the facility and proceeded to the housing units from the INS section. As he entered the secure perimeter he noted that both exterior security doors were locked in the open position. As he proceeded through the facility he observed that detainees were assaulting the security glass with a large unsecured table. He proceeded to the Control Room in an attempt to locate ESMOR personnel. He was informed by the guard stationed in the Control Room that the other ESMOR guards were in the parking lots and that they had abandoned the facility.

Officer Uzzle continued to monitor the nascent disturbance and noted that detainees retreated from the security windows when he approached them. Observing this, he proceeded to the parking lot and attempted to persuade and then direct the ESMOR guards to re-enter the facility in an attempt to establish order. ESMOR personnel refused. Officer Uzzle then directed the ESMOR guards to form a perimeter, locate and identify potential breaches, and await additional assistance.

At 1:30 a.m. Officer Uzzle re-entered the facility to reassess the disturbance. During this assessment detainees broke through the security glass and gained access to the hallways. Officer Uzzle was forced to evacuate from the secure section of the facility when it became apparent that

detainees had broken out of the secure dormitories and into the hallways of the interior of the facility.

It is estimated that approximately 15 minutes passed from the time ESMOR guards vacated the facility and detainees gained access to the interior hallways of the facility. During this time, ESMOR guards made no attempt to regain control of the facility or quell the disturbance other than to call 911, the local emergency assistance number. It is reported by Officer Uzzle that ESMOR guards had access to riot helmets, batons, and protective shields, but did not avail themselves of this equipment. The refusal of ESMOR to follow policy and procedures outlined in the emergency response plan, afforded the detainees both time and opportunity to take over the facility.

Officer Uzzle recounted that emergency assistance began arriving at 1:40 a.m. By the time local law enforcement officers arrived on the scene the facility had been taken over by detainees. Additional delays in responding to the disturbance were experienced due to jurisdictional concerns raised by local law enforcement entities. For example, the Patrol Sergeant for the Elizabeth Police Department was unwilling to commit local police resources without higher command authorization. (because of concerns over jurisdiction). At this point the area within the secure perimeter of the facility (which was not breached) was under the complete control of the detainees, and four ESMOR guards (three males and one female) were unaccounted for. Local, State, and Federal Special Weapons and Tactical Teams (SWAT) were dispatched to the site because of the potential hostage situation.

Between 1:45 a.m. and 5:30 a.m., two of the missing male guards escaped from the Control Room through the ceiling and broke out of the secure perimeter via the crawlspace between the warehouse roof and the drop ceiling. The female guard was released by detainees after being assaulted (non-sexually) and slapped by some of the male detainees. The last guard was extricated from the facility by SWAT Team members at approximately 5:30 a.m.

At 6:00 a.m. various SWAT teams followed by agents, and local and State police officers entered the facility and regained control. Order was restored within fifteen minutes of the tactical entry into the facility. A specific decision was made by the officers making the entry that they would enter without firearms so there would be no unintentional firearms related injuries or deaths. The entry into the facility by authorities resulted in 24 detainees being treated for minor wounds, most of which were caused by glass and other debris resulting from detainee actions. Injured detainees were treated and released by triage or from local hospitals after minor treatment for their injuries. No officers were injured.

C. Disturbance and Aftermath

The following are the Assessment Teams findings of fact, and conclusions related to events and/or actions during and after the disturbance.

1. Thirteen ESMOR guards, one ESMOR supervisory guard, and the INS COTR were present in the facility when the disturbance began.

2. The population in the facility at the time of the disturbance was 315 detainees. This exceeded the rated capacity of 300, but did not exceed the emergency rated capacity of 327.

3. ESMOR had not appropriately staffed all posts. Only one guard was assigned to the Control Room area, and only one guard was assigned in the female section.

4. The Assessment Team determined, based on an evaluation of the ESMOR physical plant, that the staff-to-detainee ratio was inadequate to provide necessary coverage for this facility.

5. ESMOR personnel made no effort to retrieve emergency equipment or prepare for emergency operations.

6. ESMOR had an emergency plan but failed to follow prescribed procedures or to safeguard uninvolved detainees.

7. ESMOR guards made no attempt to remove and safeguard female detainees, none of whom were initially involved in the disturbance.

8. The departure of ESMOR personnel from the facility without any tactical response allowed the detainees access to all areas within the secure perimeter of the facility.

9. Some security doors were left open by the Control Room guard, allowing detainees free access throughout the interior of the facility.

10. When the order to evacuate was given, the Control Room guard failed to release the security door to the female section, trapping the female guard and uninvolved female detainees inside the facility.

11. Critical time was lost due to the non-response of ESMOR guards to the disturbance.

12. The ESMOR personnel on-site were not adequately trained. They were not prepared for a disturbance of any kind.

The Assessment Team found the ESMOR facility was unprepared to handle any but the smallest disturbances. The rapid departure of guards from the facility allowed rebellious detainees to gain additional support from other detainees who were not likely to have otherwise participated in the disturbance.

Norman Uzzle, INS COTR, was the only INS Officer on duty at the time of the disturbance. Officer Uzzle is a long serving Officer, very competent, with substantial experience and a fine record. Great weight must be given his evaluation and judgment of the events of June 18.

According to Officer Uzzle's report, during the initial phase of the disturbance, many detainees retreated and abandoned their destructive behavior when Officer Uzzle appeared in the security window. Observing this, Officer Uzzle encouraged and directed ESMOR guards to re-enter the facility in an attempt to restore order. ESMOR personnel refused. The Assessment Team concludes that ESMOR guards did not re-enter the facility because their training and experience did not prepare them for this type of confrontation. Had ESMOR personnel been properly equipped and trained, and had staffing been at a proper level, this disturbance could likely have been quelled. It certainly could have been contained and controlled until additional assistance from local authorities arrived.

A staffing analysis was conducted by the Assessment Team for the shift during which the disturbance began. It would not have been possible for 13 personnel to cover all posts during the shift. A flaw in the original statement of work did not place a requirement on the contractor by the government to increase staffing proportionate to detainee levels. We conclude a minimum of 20 personnel would have been necessary to cover all posts for the midnight shift. This is both an error on the part of ESMOR and the INS. The Assessment Team estimates ESMOR could not, with current staff, maintain the minimum posts without the daily use of excessive overtime.

It is the finding of the Team that the Newark District did not exercise due care in verifying ESMOR's claim that they had available, and had assigned sufficient staff to cover the facility on the weekend June 17-18.

ESMOR personnel acted unprofessionally during the post-disturbance shakedown and staging of the detainees, who were then outside the facility and being held in an ad hoc enclosure. Several law enforcement officials complained of the inappropriate conduct of ESMOR personnel toward detainees, once the detainees were brought out of the facility. Both INS and local law enforcement officials observed ESMOR personnel shoving and pushing detainees around the staging area when it was apparent that the detainees had been subdued and were not provoking such actions. Further verbal abuse was witnessed. INS officials ordered ESMOR guards out of the area and did not request any further assistance from them. The FBI is determining whether or not a Civil Rights investigation, concerning allegations which arose out of this incident, is warranted. Investigations are also underway to determine whether or not to prosecute some of the detainees.

A few ESMOR personnel exacerbated post-disturbance problems by their behavior and conduct in dealing with members of the media, local government officials, and attorneys requesting information concerning their clients. In one instance, a female employee of ESMOR was taped by Channel 9 (WWOR) as she confronted and verbally castigated attorney Joyce Phipps, who was in the area representing her clients. The employee blamed Ms. Phipps for problems in the facility and proceeded to yell and scream at her for a significant length of time.

Such incidents were indicative of the type of complaints that were voiced to the Assessment Team both before and after the disturbance, and served to corroborate the Team's findings regarding the conduct of many ESMOR employees.

D. Damage Assessment

Damage to Physical Plant:

Damage to the facility was limited to the interior of the building and was primarily non-structural. The only structural damage was a single breach in one of the interior walls of a housing unit. The wall breached was the innermost wall of a double outer wall design. The outermost wall was never breached. The medical, food service, laundry, and INS areas sustained no damage; nor was there damage to sensors, alarms, and comfort control systems. These major components were left untouched.

The most significant damage occurred in the control room area. All monitors, a main door-control electronic panel, and closed circuit television (CCTV) equipment was damaged or destroyed. This will have to pass an inspection before detainees can be re-introduced to the facility.

Damage to televisions, tables and offices within the interior of the facility was heavy. Most of the tables and beds were not properly secured to the floor. Only two of four points were fastened down into the concrete floor. The detainees were able to break legs away from tables which they then used as battering rams against security windows. These windows were not designed to withstand this type of assault longer than 10-15 minutes. Had the tables and beds been more securely fastened, it would have taken the detainees considerably longer to break them away from the floor, providing critical additional minutes for emergency assistance to arrive.

Virtually every interior window in the facility was broken out or damaged. Most of the sinks and toilets were damaged beyond repair. Some cinder block walls, used as dormitory area dividers, were destroyed. The majority of the damage was to equipment, electronics, divider walls, tables, beds, porcelain fixtures, papers and other accouterments. There was extensive flooding throughout the interior facility. A substantial amount of water leaked out into areas to which the detainees never gained access. The source of water was from broken sinks, showers, and toilets, along with broken

off fire sprinkler nozzles. The facility did not permit smoking, thus no fires were set by those causing the disturbance.

Beginning the day after the disturbance ESMOR brought in a considerable work force to work round the clock. As of June 23, the last day the Team was at the facility, all water and debris was off the floor, windows and electronics were being installed, many divider walls were rebuilt, tables and beds were being anchored in a more secure fashion (with four anchor points) It was noted that ESMOR was replacing security windows with three bonded sheets of 1/4 inch lexan (a shatter proof, assault resistant plastic). This is a much more secure type of window covering than that which was broken out during the disturbance.

Electrical and Utility Damage:

Electrical damage and utility damage appears to have been limited to fixtures and outlets. The Assessment Team did not see any indication nor did the on-site contractor note any serious electrical damage or damage to the utility access areas and runways. This would not be a significant factor in repairs to the facility.

As indicated on page two of this report, on July 8 ESMOR notified INS that repairs to the facility have been completed.

VI. Recommendations

Note: **This section is a compilation of the recommendations found throughout the document, and some recommendations *related* to issues discussed in the document, but determined not to be specifically germane enough to warrant inclusion above.**

Detainee Welfare

- ESMOR should be required to submit to the INS a plan of action or policy and procedure which describes what steps will be taken to notify the INS COTR of any incidents which involves a detainee.

- ESMOR should be required to provide INS copies of complaints made against ESMOR. They must include complaints by the general public, attorneys, or other private or public interest groups. This would apply to complaints concerning treatment of detainees and/or conditions of confinement. ESMOR must also provide to the INS COTR for his follow-up, a copy of their response if any and a report of what actions they took to resolve the complaint.

Policies / Practices / Emergency Plan

- o ESMOR should be required to notify the INS COTR in writing of every change in policy and procedures for review and approval.
- o INS should physically inspect the segregation unit daily.
- o INS should require ESMOR to develop and implement a sound transportation policy which ensures aliens depart on scheduled flights with all property, funds and valuables, as required under the contract.
- o ESMOR must provide tighter controls over the processing, storage and accounting of personal property. ESMOR needs to develop an auditable procedure for assuring the proper safeguards of all detainee property.
- o The contract should be modified to require that INS more closely monitor the quality of ESMOR training.
- o The District should develop an emergency response plan to react to emergent situations at the facility.

Reporting and Internal Controls

- o ESMOR should provide to INS all incident and disciplinary reports on ESMOR personnel. If necessary, the contract should be modified to reflect this to ensure compliance. (Re: In terminations, suspensions, and any other personnel actions taken, the finding must be reported.) Through this procedure INS would have had a much clearer picture of contract employee behavioral problems.
- o The contract should be modified to allow the COTR more direct authority to intervene in practices which may adversely affect the INS.
- o Require formal INS approval of all ESMOR policies and procedures.

Staffing and Personnel Issues

- o ESMOR must provide satisfactory written evidence of appropriate staffing levels to INS under the terms of a modified contract. An INS review should be conducted monthly for the life of the contract to ensure compliance with minimum staffing requirements set out in the contract.

- INS should require ESMOR to provide an exact staffing plan for detainee populations of 200, 250, and 300 before the facility is reopened. These staffing plans should be monitored, and ESMOR should be required to comply with reporting requirements including, but not limited to, notifications of personnel on staff, suspensions, and terminations. If necessary the contract should be modified to reflect this change.

- Newark District should more closely monitor facility population level and , with Region, act more quickly to reduce the population level when necessary.

- The contract should be modified to reflect the necessary classification change in the guard series. to attract better qualified applicants.

- Newark District/Region should exercise increased vigilance to ensure all ESMOR on-duty staff have proper clearances or waivers.

- Based upon the past performance of the Security Officer and the lack of confidence expressed by RODDP, HQSEC should continue its review and assessment of the Administrative Center Burlington Office of Security and, if necessary, institute systemic improvements.

- Remedial training or hands-on informational training should be provided to ensure there is no repetition of problems in the security clearance process.

Training

- ESMOR should be required to submit proof of a comprehensive training plan which ensures that all ESMOR personnel will receive the appropriate amount of training and orientation in a timely manner.

- ESMOR should be required to submit a monthly report to the COTR, detailing the amount of training, type of training provided, and names of employees receiving the training

- The INS COTR must more closely monitor the ESMOR training program and records to ensure the accuracy and completeness of the information provided by ESMOR.

Food Service

- ESMOR and INS should create a system to more closely monitor detainee complaints about food, determine if the complaints have merit, and provide the detainees with specific responses

Medical Care

- PHS should take over the functions of all medical services provided on-site. Resources have been identified and such a move would be both cost effective and prudent given the consequences should a detainee not receive appropriate care while in Service custody.

Access to Counsel / EOIR / INS

- ESMOR should post in a convenient place the visitation policy and any subsequent changes in policy.

- Attorneys who regularly practice immigration law, along with free legal service groups, should be notified by mail of any changes in the visitation policy. INS should be able to provide lists of free legal service groups.

- ESMOR should consider a method of scheduling a certain number of attorney visits. This could be done on a mutually acceptable schedule.

The Physical Facility

- ESMOR should be required to comply with the contract in adherence to ACA standards.

- INS' procedures to accept a facility for operation need to be strengthened.

Contract Compliance

- The INS COTR be provided by ESMOR with daily reports to learn of all incidents between detainees and guards. The Facility Administrator should report any incidents or allegations of misconduct to the INS COTR in a timely manner, as outlined under the terms of the contract.

- The ACBADM Contracting Office needs to pursue the addition of the skylights in the segregation area.

- The INS COTR needs to work with the Facility Administrator to ensure a single logbook which contains at least a minimum of the following information is kept within the control area and is available to the INS COTR or other reviewing INS Officer upon demand: (1) the personnel on duty; (2) detainee counts and security checks; (3) shift activities and; (4) any incidents, assaults, emergencies, or similar situations.

- ESMOR must ensure a more effective method of maintaining logbooks which allow for Central Control to receive information at a single location regarding all significant incidents.

- The INS OIC should place a grievance box in each dormitory for the sole use of detainees. Detainees will be able to provide, directly to the INS, complaints, allegations, or other information which previously has not been provided by the contractor. The INS representative should no longer participate in the meetings between ESMOR and the detainees. Emphasis should be placed on instituting a two-way grievance system under which the INS would acknowledge receipt of complaints and indicate that they are being looked into. Such a system would facilitate the process of documenting the contractor's follow-up on complaints in a written form; provision being made for illiterate and/or non-English speaking detainees to present their complaints.

- The COTR needs to monitor daily personnel assignments more closely.

- The use of staff on double shifts is a hazardous practice and should be limited under the terms of the contract. to those instances approved by the COTR for emergent circumstances.

- Guards should not be allowed to work more than four hours beyond the normal eight-hour tour of duty.

- When it becomes apparent that inadequate personnel are available to ensure appropriate coverage. the COTRs should request that RODDP consider a decrease in the daily population until ESMOR can provide evidence of compliance and a continued ability to provide personnel for each post.

- The contract fails to define "tour of duty" or address the limits of the tours. The INS needs to modify the contract to reflect that the official tour of duty is eight hours. The contract must spell out exactly when overtime and double shifting are permissible.

- Increase INS oversight of the contract to 24 hours a day, seven days a week. This will ensure proper performance of ESMOR staff.

- The COTR needs to immediately put the contractor on notice of any contract violations.

- ESMOR must be required to provide timely reporting to the INS of any violation of detainee rights.

- ESMOR must provide tighter controls over the processing, storage and accounting of personal property. ESMOR needs to develop an auditable procedure for assuring the proper safeguards of all detainee property. Any discrepancies in these records must be reconciled prior to a detainee's day of departure. Consideration should be given for the contractor to adopt INS' own rigid control procedures for handling detainee funds and valuables.

- Any adjustments taken on the contractor's monthly invoice should be supported by a detailed description of the violation and the amount being withheld.

Recommended Contract Modifications

- Identify appropriate levels of staffing per number of detainees for this specific site.

- Incorporate a requirement for a Quality Assurance Plan that provides the contractor and the Government the detailed information necessary to assure a high standard of service is being provided and meets the INS' needs. This will also allow the contractor and INS to take a proactive approach in identifying problem areas and take timely action.

- Provide for continual monitoring and visibility into the contractors operations through detailed and timely reporting requirements.

- Develop a list of quality indicators against which to measure the contractor. This will assure the level of service remains at a level required by INS and identify problem areas.

- Require quarterly reviews of the contractor's performance.

- Reexamine the qualification requirements of the contractor personnel to determine if they are at an appropriate level for the duties required under the contract.

- Sufficient INS presence should be required in the facility on a 24 hour, seven-day-a-week basis. If this recommendation implemented by authorizing user fee DEOs, the those DEOs assigned to the District should be returned to those functions for which they were originally allotted.

The Newark District

- All ESMOR's Post Orders, Policies, and Procedures should be further re-reviewed and approved by RODDP and HQDDP concurrently within 30 days of the release of this report.

INS' Juvenile Detention Policy

- The Newark District should be directed to closely adhere to both the regulations in 8 CFR 242.24. and the 1991 policy memorandum regarding the detention of juveniles; placing particular emphasis on fact that the 72 hour limit for detention of alien minors commences when INS assumes custody of the juveniles.

Office of Security

- HQSEC should continue its review and assessment of the Administrative Center Burlington Office of Security and, if necessary, institute systemic improvements.
- Remedial training or hands-on informational training should be provided to ESMOR to ensure there is no repetition of problems in properly utilizing the security clearance system.

Community Relations

- The Newark District should develop a better working relationship with the Congressional delegation. attorneys. the local community, and others who have a vested interest in the manner for which INS conducts its business
- In support of the immediately prior recommendation, the District should form a Community Working Group, composed of individuals from INS, ESMOR, and members of the entities noted above. This group could meet monthly, or as needed, to ensure community participation in issues of community interest.
- The District should work with ESMOR to provide easier (but controlled) access to the facility for concerned parties in the community.

RODDP / ACBADM

- INS must ensure that ESMOR is providing accurate verifiable information. Currently daily communication is made only to discuss an existing problem. An open line of communication needs to be maintained on a daily basis instead of weekly, whether or not a current problem exists.

The Hearing Process

- A cooperative review between INS and EOIR should be conducted to examine the INS-EOIR relationship, to identify and resolve problem areas.
- In the future, INS should involve EOIR at an early stage of facility planning. This would ensure the interests of both agencies were better represented.
- INS should work with EOIR to better clarify, at an early stage, funding issues related to new detention facilities.
- The current contract with ESMOR should be modified to implement changes needed to support the hearing process.
- The District should ensure that counsel for detainees are apprised of the transfer of their clients. When possible, they should be notified prior to the transfer.
- The District should ensure that detainees have easy access to a current list of *pro bono* legal representatives.
- Detainees should have the opportunity to make direct (non-collect) telephone calls to *pro bono* legal representatives.
- INS Headquarters should publish its policy on whether or not there is a need for attorneys to file Form G-28 (Notice of Appearance of Attorney or Representative) in order to visit non-client detainees in custody.
- Increased effort should be made to establish a pro bono program at ESMOR, similar to that at the INS facility in Florence, Arizona.
- The contract should be modified to require ESMOR to establish practices that better accommodate the defined needs of the Immigration Court.

Acknowledgement:

The Assessment Team wishes to acknowledge that it could not have obtained much of the above information without the direct and constant support of the Newark District. The Newark District Director acknowledged that problems did exist and was making every effort to regain control of those problems when the Assessment Team arrived. All items requested from the District staff were provided without question or comment and in a manner that was professional. We were treated with a great deal of hospitality and every courtesy was extended to the Team during this assignment.